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MEDICARE AND MEDICAID AMENDMENTS OF 1979

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 4000

NOVEMBER 5, 1979.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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MEDICARE AND MEDICAID AMENDMENTS OF 1979

NOVEMBER 5, 1979.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. ULLMAN, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 4000 which on May 8, 1979, was jointly referred to the Committee on Ways and Means and the Committee on Interstate and Foreign Commerce]

The Committee on Ways and Means, to whom was referred the bill (H. R. 4000) to amend the Social Security Act with respect to health programs authorized under it, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment strikes out all after the enacting clause of the bill and inserts a new text which appears in italic type in the reported bill.

I. PURPOSE AND BACKGROUND OF THE BILL

Programs of the magnitude and complexity of medicare and medicaid require continuing review, analysis and modification if they are to retain their full effectiveness and achieve the objectives set for them by the Congress. In recognization of this fact, your Committee has been engaged in a continuous process of program evaluation (resulting in the identification of a number of problem areas) as well as an ongoing assessment of a large number of legislative proposals made to resolve them. Most recently, your Committee has conducted several oversight and legislative hearings to evaluate proposals to correct critical deficiencies in several areas, including the performance of peer review activities, the availability and quality of long-term care services, the prevention of fraud and abuse (as well as deceptive practices in the marketing of private health incurance policies for the aged) and the inadequacies of current program incentives for the stimulation of alternative health care delivery systems.

In conducting these reviews and hearings, your Committee has examined a considerable body of proposed legislation including major

Administration legislative initiatives relating to the PSRO program, fraud, medicare and medicaid benefit and administrative improvements, health maintenance organizations, and long-term care. (Administration proposals were contained in three bills—H.R. 4106, H.R. 4444 and H.R. 4475—which were considered in detail by the Committee's Health Subcommittee as well as the full Committee.) A number of other bills and views were also considered by your Committee during these sessions in an effort to obtain the widest possible expression of opinion, analysis and recommendations for solutions.

A a result, the Committee believes that H.R. 4000, as reported, reflects a careful distillation of recommendations for addressing some of the more urgent operational problems of these two programs. While the committee recognizes that other pressing program problems need to be addressed, the Committee believes that effective solutions for these problems are not yet available and that it is preferable to proceed at this time with changes that represent demonstrable improvements. Thus, the committee's bill includes several provisions making modifications in the administrative structure of the programs to enhance the capacity of individual peer review organizations to more effectively review matters of quality and necessity, to improve the implementation of quality standards for health care providers, to intensify administrative efforts to more effectively detect and prosecute fraud, to provide additional means for assuring the protection of aged consumers against deception in the sale of private health policies, and to enhance incentives for more efficient delivery of health care. Your committee believes that these measures will considerably improve the overall efficiency of the programs and will result in substantial savings while, at the same time, improving the protection afforded by the programs to persons legitimately in need of health care services. Your committee believes, therefore, that the bill represents an equitable and responsible approach to the resolution of critical administrative problems in these two programs.

II. Summary of the Bill

As reported, H.R. 4000 includes provisions relating to the operation of the Professional Standards Review Organization (PSRO) program, the availability and quality of long-term care services (including provision for the use of excess hospital beds as long-term care beds on a swing-bed basis), additional protection against fraud and abuse in the medicare and medicaid programs, a voluntary certification program for private insurance supplementing medicare, and a revision in the current method for reimbursing health maintenance organizations (HMO) under medicare.

The PSRO provisions of the bill are designed to imrove PSRO performance by focusing peer review activities on areas of abuse, increasing nonphysician participation in the development and implementation of peer review activities and tightening administration of the program.

The provisions dealing with long-term care are intended to assure that skilled nursing facilities meet quality standards while at the same time minimizing some of the administrative burdens currently

imposed on such facilities. Since there is considerable concern about the availability of skilled nursing facility services, the bill directs the Secretary to study the causes of the present scarcity of available skilled nursing home beds for medicare and medicaid beneficiaries and the extent to which existing laws and regulations contribute to this problem. The bill also authorizes, for purposes of medicare and medicaid reimbursement, the use of acute care beds by hospitals to provide skilled nursing care services that would otherwise be covered if furnished in a skilled nursing facility.

The provisions in the bill relating to fraud and abuse are designed to supplement the medicare and medicaid anti-fraud and abuse bill enacted during the 95th Congress, P.L. 95–142. Among these provisions is authority for the Secretary to impose a civil money penalty, subject to judicial review, for a fraudulent claim for reimbursement and to exclude health care practitioners convicted of medicare related crimes from participation in the program.

Because of concerns about the problems faced by aged beneficiaries in selecting appropriate private supplementary policies, the Committee's bill includes provision for the creation of a certification program under which private insurers may request the certification of policies by the Secretary as in compliance with minimum standards relating to retention ratios, exclusions, and clarity of policy language. In addition, the bill provides for a study by the Secretary of the effectiveness of existing State regulatory programs for such private insurance.

The bill also includes provision for health maintenance organizations to elect to be reimbursed by medicare on a risk basis. Under such an agreement, the HMO would receive, on a prospective basis, 95 percent of the per capita amount the Secretary estimates would be paid for services provided to medicare beneficiaries by other providers in the geographic area of the HMO.

III. General Statement

SHORT TITLE (SECTION 1)

This Act may be cited as the "Medicare and Medicaid Amendments of 1979."

EXPANDED MEMBERSHIP OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (SECTION 2)

The bill authorizes each professional standards review organization (PSRO) to offer membership, at its own option, to nonphysician health professionals who hold independent hospital admitting privileges.

Under present law, membership in a professional standards review organization is limited to licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in the organization's area. However, the provision of health care services furnished in a hospital setting may involve orders by independent health professionals other than physicians; for example, dentists and podiatrists. Since such health professionals hold hospital admitting privileges in many juris-

dictions and order services for which payment may be made under medicare, your Committee believes it would be appropriate to provide the opportunity—consistent with established professional relationships in each community—for such professionals to participate in the evaluation of these services as members of the PSRO. It is expected that such membership, where the invitation is extended by the PSRO, would be made available under the same general conditions now applicable to doctors of medicine or osteopathy. The bill retains, however, the requirement of existing law that only doctors of medicine or osteopathy may make final determinations with respect to the services performed by other M.D.'s or D.O.'s.

Although your Committee believes that it would be desirable for the boards of local PSRO's to include consumer representatives, the Committee believes that such a decision should be left to the option of each organization. Many PSRO's have already, on a voluntary basis, invited consumer representatives to sit on their boards and the Committee believes that such voluntary actions should be encouraged.

REGISTERED NURSE AND DENTIST MEMBERSHIP ON STATEWIDE COUNCIL ADVISORY GROUP (SECTION 3)

The bill provides that at least one registered professional nurse and one dentist would have to be included in the membership of the advisory group to each Statewide Professional Standards Review Council.

Under present law, the advisory group to a Statewide Council must be composed of representatives of health care practitioners (other than physicians) and health care institutions. In recognition of the impact the nursing and dental professions have on the delivery and quality of care, your Committee believes it is desirable to require each Statewide Council advisory group to include, in addition to representatives of other appropriate professional disciplines, at least one registered professional nurse and one dentist.

NONPHYSICIAN MEMBERSHIP ON NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL (SECTION 4)

Under the bill, the membership of the National Professional Standards Review Council would be expanded to include a dentist, a registered professional nurse, one other nonphysician health professional, and a consumer representative.

Under present law, membership on the National Council, which advises the Secretary on policy and administrative matters relating to the PSRO program, is limited to doctors of medicine and osteopathy. Your Committee believes, however, that since the National Council is responsible for providing policy and administrative advice on all services covered under medicare, including services furnished by nonphysician health professionals, such a limitation on membership detracts from the effective performance of the Council's function. Providing for the membership of representatives of the nursing, dental and other health care professions would enhance the exchange of professional judgments on standards and utilization of services among these disciplines. The Committee has added a consumer representative to the Council because

so much of the Council's work is devoted to issues directly affecting the delivery and use of health services. In your Committee's judgment, the presence of a consumer representative would enable the council to more effectively assess the potential impact of various professional and administrative policies on the public.

The Committee expects that the Secretary, in selecting the member to represent the several nonphysician health disciplines, will develop a selection process that will assure both the equitable rotation of the position among the recognized scientific health care disciplines and the selection of a representative of recognized standing and distinction in his chosen scientific field.

ADVISORY COMMITTEE TO THE NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL (SECTION 5)

The bill provides for the creation of an Advisory Committee to the National Council, composed of nonphysician health professionals.

Currently, there is no formal national structure available to the National Council as a professional resource with respect to the services of nonphysician health professionals. Your Committee believes that if PSRO's are to serve as catalysts for improving the efficiency and quality of health care services through systematic review, it is essential that representatives of nonphysican health disciplines be formally involved at the national level. Such involvement through an advisory committee would help to assure that national policies, procedures, and guidelines reflect the professional experience and expertise of the many recognized scientific health care disciplines. It is expected that the Secretary, in establishing the Advisory Committee, will take appropriate steps to assure the equitable representation of the several disciplines which are recognized by and work closely with the medical profession and are engaged in providing therapeutic and restorative services, vision care, laboratory, social, pharmaceutical, and medical recordkeeping services.

REQUIRED ACTIVITIES OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (SECTION 6)

The bill provides that a conditionally designated professional standards review organization could become fully designated if the organization, at a minimum, is satisfactorily conducting reviews of health care services provided by or in all hospitals in its area. The bill would also eliminate the requirement of present law that a PSRO must, if capable, review long-term and ambulatory care services within two years of becoming fully designated, and provide instead that the Secretary is to determine, with respect to each fully designated PSRO, when and the extent to which the organization must conduct reviews of services other than those provided by or in hospitals. Under the bill, the Secretary would be authorized to designate another qualified professional standards review organization to conduct reviews of services not yet being performed by such a designated PSRO.

Under present law each PSRO is required to assume review responsibility for care delivered by or in all types of institutions within four

years of receiving conditional designation. The law further permits an extension for two additional years of a conditionally designated PSRO's trial period if failure to implement reviews in all types of institutions is due to causes beyond the PSRO's control. Within two years of receiving full designation, however, the Secretary must require those PSRO's with the capability to review ambulatory care services to assume this responsibility.

Although the Committee favors the prompt and orderly expansion of PSRO review activities into the areas of long-term and ambulatory care services, your Committee recognizes that review methodologies for evaluating the medical necessity of such services are still in the developmental stage. Moreover, the information furnished to your Committee on current PSRO capabilities indicates that many PSRO's which are effectively reviewing inpatient hospital care are not prepared at this time to undertake additional responsibilities. In the Committee's judgment it would be ill-advised, from the standpoint of effective program administration, to require such PSRO's to prematurely implement additional review activities. Since such a result could occur under present law, your Committee's bill would permit those PSRO's which have been conducting effective hospital review to continue as fully designated for purposes of inpatient hospital review, while designating those PSRO's as planning or conditional for long-term and ambulatory care review. In addition, the bill would permit the Secretary, in such cases, to designate another qualified PSRO (in reasonably close proximity to the conditional PSRO) which does have the capacity to effectively review long-term and ambulatory care services to assume that responsibility until the conditional PSRO has acquired the capacity to take on such responsibility.

DIIRECT REIMBURSEMENT FOR PROFESSIONAL STANDARDS REVIEW OF HOSPITAL SERVICES (SECTION 7)

The bill provides for direct reimbursement of administrative costs to a PSRO where it is performing hospital reviews.

Under present law, a hospital has the option of receiving medicare payment for a PSRO's review of its services and then passing the payment on to the PSRO. Although this pass-through option was originally intended to help expedite the identification and reimbursement of administrative costs associated with the review process, it has, in practice, unnecessarily complicated the PSRO reimbursement process. Your Committee's bill would, therefore, eliminate the pass-through option and provide for direct payment of administrative costs to PSRO's.

CONSULTATION BY PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS WITH HEALTH CARE PRACTITIONERS (SECTION 8)

In lieu of the present requirement of formal advisory groups of health care practitioners to individual PSRO's, the bill would authorize the Secretary to establish more flexible guidelines to assure appropriate operational PSRO consultation with representatives of all health care disciplines on the performance of review activities.

Present law requires that advisory groups to PSRO's must be established and must be composed of not less than seven or more than eleven

members who are representatives of health care practitioners other than physicians. Such formal advisory groups, however, have proved to be cumbersome and not totally effective in assuring appropriate consultation on operational matters. Your Committee believes that more effective and practical arrangements could be achieved by authorizing the Secretary to establish and apply flexible guidelines relating to organizational relationships—including the range, frequency, and continuity of contacts—for assuring operational PSRO consultation with all health care disciplines.

REVIEW OF ROUTINE HOSPITAL ADMISSION SERVICES AND PREOPERATIVE HOSPITAL STAYS BY PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (SECTION 9)

Under your Committee's bill, PSRO's would be directed to focus review on those areas of relatively frequent overutilization—particularly routine hospital admission services and excessive preoperative stays—to assure that medicare and medicaid payments are made only when the routine tests and unusually long preoperative stays for elective conditions are medically appropriate.

Present program policies direct PSRO's to review the appropriateness of hospital services received by medicare and medicaid patients. This review has been limited largely to a review of the need for the patient to be admitted to the hospital and the appropriateness of the length of stay. However, it has been brought to your Committee's attention that a number of studies have demonstrated that unnecessary or avoidable utilization occurs with respect to certain hospital practices that have not been subject to general across-the-board review, including: diagnostic tests routinely provided on admission without a physician's order; weekend elective adminissions to hospitals which are not equipped or staffed to provide needed diagnostic services on weekends; and preoperative stays for elective procedures of more than one day without justification for the additional days. Consequently, under the Committee's bill, PSRO's would be directed to review these areas of overutilization and to assure that no payments are made for medically unnecessary routine hospital services or preoperative days.

STUDY OF PSRO NORMS, STANDARDS AND CRITERIA (SECTION 10)

The bill requires the Secretary to conduct, in consultation with the National Professional Standards Review Council, a nationwide study of the differences in PSRO's medical criteria and length-of-stay norms. The Secretary would be required to report the findings of this study to the Congress within one year of enactment, together with recommended actions to be taken to eliminate regional differences which are not justified by scientific or demographic evidence or unique climate or geographic conditions.

Present law requires PSRO's to use professionally developed norms of care based on typical patterns of practice in their areas, and also requires the National Council to exercise oversight and approval over PSRO norms which are significantly different from professionally developed regional norms.

Your Committee believes that basing PSRO criteria and norms exclusively on typical practice patterns in the area may serve to

perpetuate the status quo, including whatever inappropriate practices may be present in the area. While there are legitimate reasons for some variations in medical criteria and norms from area to area, there is also substantial evidence of widely different criteria and norms for similar patients under similar conditions. For example, the typical length of stay for a gall bladder removal varies by as much as 6 days in different sections of the United States. The intent of the study provided for in the bill is to determine what basis there is for such differences and to ascertain whether some steps might be taken to avoid the perpetuation of inefficiences.

AGREEMENTS WITH SKILLED NURSING FACILITIES (SECTION 11)

The bill authorizes administrative flexibility in establishing the term of an agreement with a participating skilled nursing facility so as to allow the Secretary to extend the term beyond 12 months in the case of a facility consistently in compliance with the medicare conditions of participation.

Your Committee believes that the requirement of present law that every skilled nursing facility be surveyed annually is no longer necessary since program experience indicates that many facilities have been consistently in compliance with medicare's health and safety standards. Moreover, it is generally agreed that the present requirement limits the ability of a State to concentrate its resources on those facilities that require closer scrutiny. Under the Committee's bill, the practice of annually surveying those facilities that have significant deficiencies would be continued; however, the bill would permit surveys at less frequent intervals in the case of a facility that has been found to be consistently in compliance with the standards. It is your Committee's intent that such intervals would be consistent with the practice generally followed by the Secretary in surveying hospitals participating in medicare, and that only in exceptional cases would a skilled nursing facility be surveyed less frequently than at 24-month intervals.

CONSULTATIVE SERVICES FOR SKILLED NURSING FACILITIES (SECTION 12)

Under the bill, the provision of present law authorizing medicare reimbursement for consultative services furnished by State agencies to skilled nursing facilities would be repealed.

Under present law, the State agency responsible for determining skilled nursing facility compliance with medicare conditions of participation may furnish specialized consultative services, at the request of the facility, to help it achieve or maintain compliance with the conditions. However, since there have been no requests under this provision for medicare funding of consultative services, it is apparent that the provision is unnecessary. Moreover, your Committee believes that adequate provision has been made under the medicaid program for furnishing consultation to any skilled nursing facilities that might require such services.

STUDY OF NEED FOR DUAL PARTICIPATION OF SKILLED NURSING FACILITIES (SECTION 13)

The bill requires the Secretary to conduct a study of the causes for the present scarcity of skilled nursing home beds, including the extent

to which existing laws and regulations (as well as other factors) discourage dual participation of skilled nursing facilities in the medicare and medicaid programs, and report the results of the study to Congress within one year after enactment.

Under present law, skilled nursing facilities are not required to participate in both the medicare and medicaid programs. As a result, there are a number of areas of the country in which there are fewer beds available, either for medicare or medicaid beneficiaries, than might otherwise be the case if all skilled nursing facilities participated in both programs. While there are many opinions as to why a large number of facilities choose not to participate in both programs, your Committee believes there is little documentation and objective analysis of the reasons for this situation. To eliminate this gap in knowledge, the bill would direct the Secretary to conduct a thorough study of the situation and assess the feasibility and potential consequences of requiring dual participation. In conducting the study, the Secretary would be required to consult with professional organizations, private insurers, nursing home providers and consumers of skilled nursing services, and would be required to submit a report on the results of the study together with any recommendations for legislative changes.

ALTERNATIVE TO DECERTIFICATION OF SKILLED NURSING FACILITIES OUT OF COMPLIANCE WITH CONDITIONS OF PARTICIPATION (SECTION 14)

In lieu of decertification of a skilled nursing facility out of compliance with the conditions of participation, the Secretary would be authorized to deny reimbursement for services furnished by the facility to medicare and medicaid beneficiaries admitted after a date designated by the Secretary until such time as the facility corrects, or is determined to be making good faith efforts to correct, its deficiencies. The Secretary would be required to provide a hearing for the facility before applying this sanction and to provide notification to beneficiaries of such action.

Under present law the only sanction that may be imposed on a skilled nursing facility that is out of compliance with the conditions of participation is to terminate its participation in the medicare and medcaid programs. Thus, even in cases where the facility's failure to meet standards may be marginal, or at least not sufficient to jeopardize patient health and safety, the Secretary has no recourse but to decertify the facility and transfer the medicare and medicaid patients. Unfortunately, there are significant risks and hardships associated with the transfer of such patients to other facilities. In addition, there is a reluctance to decertify a facility where there are no alternative facilities nearby in which to house displaced patients.

Under the Committee's bill, the Secretary would be authorized to deny reimbursement for services furnished to beneficiaries admitted after a date designated by the Secretary until such time as its deficiencies have been corrected or it is determined that the facility is making good faith efforts to correct its deficiencies. This sanction would be applicable for a limited period, not to exceed 12 months, after which the Secretary would be required to decertify the facility if it has failed to make good faith efforts to correct the deficiencies.

Under the bill, this sanction could not be applied until the facility, in accordance with existing medicare policies on the correction of pro-

vider deficiencies, has had an opportunity to develop and implement a plan for correcting its deficiencies. Following the facility's failure to satisfactorily meet this requirement, the Secretary could apply the sanction, but only after the Secretary has provided the facility with an opportunity to present its case at a formal hearing.

The Secretary would also be required to provide public notification to potentially affected beneficiaries of the date the sanction will take effect and the fact that no benefits will be payable on behalf of a beneficiary admitted to the facility after that date. (Benefits would continue to be paid on behalf of beneficiaries who were inpatients of the facility prior to the designated date.) The Secretary would be required to promulgate regulations setting forth the procedures for implementing this provision of the bill.

Your Committee believes that the application of this sanction, in lieu of immediate decertification of a facility, would serve to protect beneficiaries both by giving the skilled nursing facility an incentive to correct deficiencies in a timely manner and by forestalling the need for traumatic transfers of large numbers of patients during the time such needed improvements are being made in the facility.

LIFE SAFETY CODE REQUIREMENTS (SECTION 15)

The bill authorizes the Secretary to determine in regulations when skilled nursing facilities would be required to meet the provisions of revised editions of the Life Safety Code.

This provision of your Committee's bill would repeal the requirement of present law that a skilled nursing facility must meet the 1973 edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) and allow the Secretary to establish the timeframe for application of the latest edition of the Code. Since the Life Safety Code is revised by the NFPA approximately every 3 years to accommodate changes in technology or philosophy, the statutory requirement that facilities meet a specified edition of the Code creates unnecessary administrative complications and burdens on providers. Although a 1976 Code is currently in general use and a 1980 Code is under development medicare facilities are still required by law to comply with the 1973 edition of the Code. To eliminate this discrepancy and to permit the flexibility necessary to adjust to scientific developments in the fire protection field, the Committee's bill would allow the Secretary to revise the Life Safety Code requirement on a more timely basis without having to seek legislative changes. Moreover, such flexibility would reduce the regulatory burden on providers resulting from the application of unnecessary or out-of-date rules.

It is not the intent of your Committee's bill that the Secretary select among provisions from more than one edition of the Code in determining LSC requirements. Rather, one edition of the Code, in its entirely, would be adopted. The Committee expects that normally, the latest edition would be the one required. The Secretary would have authority, however, to review each new edition of the Code to assure that its provisions continue to be appropriate. The Secretary would also have authority to require adoption of a new edition of the Code within a reasonable timeframe, consistent with the capabilities of the States to conduct the necessary surveys of facilities using the new edition of the Code. Moreover, your Committee's bill would not limit the Secre-

tary's present authority to use, wherever appropriate, the equivalency standards developed by the National Bureau of Standards and incorporated by the NFPA as part of the Life Safety Code.

The Committee recognizes the potential for certain problems arising as a result of revisions embodied in later editions of the Code that may upset structural accommodations previously made by providers at some cost to them. The Committee expects the Secretary to be fully cognizant of the impact of such changes on providers and to take them into account in revising the Life Safety Code requirement. The intent of the change made by your Committee's bill is to minimize regulatory burdens on facilities, consistent with fire safety, and to assure orderly adjustments to changing technology.

CIVIL MONEY PENALTY FOR MEDICARE AND MEDICAID FRAUD (SECTION 16)

The bill authorizes the Secretary to impose a civil money penalty of up to $2,000 for a fraudulent claim for reimbursement under the medicare and medicaid programs; and to impose an assessment, in addition to the penalty, of twice the amount of the fraudulent portion of the claim. (A fraudulent claim is one submitted by a provider or supplier of services for medical items or services which were not provided, or were provided in violation of Federal or State law or regulations, or were provided in violation of an agreement with the United States or a State agency.)

Before a penalty could be imposed, the Secretary would be required to give written notice and an opportunity for a hearing on the record with the right to be represented by counsel, to present witnesses, and to cross-examine. Any person adversely affected by a determination of the Secretary under these provisions would be entitled to judicial review of the determination. In addition, the bill provides that where penalties in excess of $15,000 are assessed within a two-year period in connection with medicare and medicaid claims determined to be fraudulent, the person may request a de nova trial in U.S. District Court of all relevant facts and issues.

The intent of this provision of the Committee's bill is to provide an alternative to criminal proceedings primarily in two types of cases: (1) those in which the behavior of the alleged offender is not likely to warrant imprisonment; and (2) those which are not accepted by United States Attorneys for prosecution but which, nonetheless, involve clear violations of Federal statutes or regulations. The latter type of case represents the majority of the substantiated fraud cases in the medicare and medicaid programs. These are cases which have been subjected to a full-scale investigation as a result of which there has been a determination that there is a substantial basis for criminal prosecution.

Your Committee recognizes that United States Attorneys may decline to accept such cases for any number of reasons; for example, the U.S. Attorney has a backlog of cases; or he may lack sufficient expertise in medicare-medicaid law to prosecute and may feel the investment of time and effort to acquire the expertise is not warranted; or the number of counts or amount of money involved may not be sufficient in his judgment to warrant criminal court proceedings. None of these examples imply the nonexistence of fraud or lack of culpability on the part of the alleged offender; they only indicate the U.S. Attorney's

unwillingness to accept many cases because they appear to be unsuitable for prosecution.

Under present law, when a decision is made not to accept a case for prosecution the only recourse for the government is to attempt recovery of the overpayment involved; often with indifferent success. But even if such recovery is successful, the offender has had penalty-free use of Federal funds for a period of time. Moreover, in such cases there is little, if any, inducement to the offender not to commit the fraud again. Your Committee believes that the imposition of civil money penalties would provide this inducement by both recouping the financial loss incurred by the government and by imposing a monetary penalty.

While the Committee believes that in most cases the amounts of the penalties are likely to be small, your Committee recognizes that in some cases the penalties and assessments may amount to a considerable sum of money. In such cases, there is justification, in your Committee's judgment, for permitting the person to obtain a de novo review in District Court (with an opportunity for jury trial) of all the relevant facts and issues. Thus, the bill provides an opportunity for a person to obtain de novo review by the District Court of the Secretary's determination where the penalties and assessments levied against a practitioner or provider for fraudulent claims for services rendered during a two-year period exceed $15,000. In the case of practitioners and providers reimbursed on a fee for service basis the two-year period would generally be computed from the last date of service in the claims or claims upon which the assessment is based. In the case of providers reimbursed on a cost or cost-related basis the period would be related to two consecutive cost reporting periods. The Committee expects the Secretary to define this methodology more precisely in regulations.

The Committee expects that the Secretary will employ this administrative procedure judiciously and with due regard to the need to proceed to criminal prosecution whenever such action seems warranted by the facts of the case. Nevertheless, the Committee recognizes the need for this procedure in the medicare and medicaid programs, and in authorizing its use the Committee had followed in its general statutory construction those penalty provisions already authorized in other Federal statutes with respect to the administrative activities of a number of Federal executive departments and independent agencies.

EXCLUSION OF HEALTH CARE PROFESSIONALS CONVICTED OF MEDICARE OR MEDICAID RELATED CRIMES (SECTION 17)

Under the bill, the provisions of present law relating to the exclusion from participation in the medicare and medicaid programs of physicians and other practitioners convicted of program-related crimes would be broadened so as to apply to other categories of health professionals, such as administrators of health care institutions.

Under present law, medicare and medicaid payment may be denied for goods and services furnished by a physician or other practitioner convicted of a program-related crime. However, similar action cannot now be taken with respect to other health professionals (such as operators or administrators of health care facilities) who are convicted of

program-related crimes. The Committee's bill would rectify this deficiency in the law. In the case of those professionals who do not directly furnish medical care or services, payment would not be made to the provider for the cost of any services furnished to or on behalf of the provider by the convicted professional in connection with either program. (The provision of present law relating to a right to a hearing on a determination of the Secretary to bar an individual from participation would be retained.) The Committee's bill also clarifies the intent of present law that the Secretary is authorized to bar a professional who may have participated only in the medicaid or medicare program from participation in both programs.

REQUIREMENTS CONCERNING REPORTING OF FINANCIAL INTEREST (SECTION 18)

The present statutory requirements relating to the reporting of financial interests as a condition of participation in medicare and medicaid would be amended by the bill to provide that an entity would be required to report only those individual interests in mortgages or other obligations equal to at least $25,000 or 5 percent of the entity's total assets. Present law requires the reporting of all interests of 5 percent or more of any such obligation secured by property of the reporting entity, even where the obligation is secured by a small portion of the entity's assets.

The Committee's bill would also clarify the states' responsibility to require compliance with the disclosure requirements of present law as a condition of participation in the medicaid program.

WITHHOLDING OF FEDERAL SHARE OF PAYMENTS TO MEDICAID PROVIDERS TO RECOVER MEDICARE OVERPAYMENTS (SECTION 19)

The Secretary's authority under present law to recover overpayments under medicare, where a provider has withdrawn or has been terminated, by withholding would be extended by the bill to instances where: (a) the provider continues to participate in medicare but at such a minimal level as to preclude recovery of the overpayment; and (b) where recovery of large medicare overpayments under part B to a physician or other health professional is precluded because the practitioner or professional is not participating in medicare (i.e., no longer accepts assignment for medicare claims).

Under present law, the Secretary can withhold the Federal share of medicaid payments from providers in order to recover medicare overpayments, but only where the provider has withdrawn or has been terminated from participation in the program. The purpose of this provision of your committee's bill is to prevent such a provider from circumventing the intent of the recovery provisions of present law by formally maintaining its status as a participating medicare provider while substantially reducing its acceptance of medicare patients. Similarly, the bill would permit recovery of medicare overpayments to physicians and professionals who subsequently elect not to accept assignment for medicare claims and thus preclude any recoupment of such overpayments through offsets against future medicare payments.

HOSPITALS PROVIDING LONG-TERM CARE SERVICES "SWING BEDS" (SECTION 20)

The bill authorizes the Secretary to enter into agreements with certain hospitals, for purposes of reimbursement under the medicare and medicaid programs, under which the hospital could use its beds on a "swing" basis as either acute or long-term care beds, depending on need. A simplified cost reimbursement formula would avoid the current requirement for separate patient placement within the hospital and separate cost finding. (This formula would also reflect the lower cost of providing less than acute care.) Hospitals which have been granted a certificate of need for the provision of long-term care services would be eligible to enter into such agreements.

Where a hospital does not have such an agreement, payment for long-term care services furnished to a beneficiary who remains in the hospital because no long-term care beds are available in the community would be made at the average skilled nursing or intermediate care facility rate (as may be appropriate) if the hospital's average annual occupancy rate is below 80 percent and the hospital could obtain a certificate of need to provide long-term care services.

Patient days of care that are paid by medicare at the reduced rate would be counted against the beneficiary's eligibility for skilled nursing facility benefits. Similarly, the medicare skilled nursing facility benefit coinsurance rates would be applicable.

Your Committee believes that a number of hospitals in areas where there is a scarcity of long-term beds could use their unoccupied acute care beds to provide a less intensive level of care. Under present law, however, such a lesser level of care furnished to medicare and medicaid patients in hospitals is not covered unless furnished in a distinct part of the hospital where beds are reserved solely for nursing care patients. The Committee's bill would allow such hospitals to use their acute care beds to provide nursing care services which would otherwise be covered under medicare or medicaid if the services were provided in a skilled nursing or intermediate care facility. In order to assure the quality and appropriate use of such services, nursing care services provided to medicare beneficiaries in such a hospital would be subject to certain skilled nursing facility conditions of participation relating to social service staffing and functions and discharge planning that are not treated as specifically in the hospital conditions of participation. The conditions that the Committee expects the Secretary to apply include: (a) the social service provisions that require the facility to make an effort to identify the patient's social and emotional needs and to employ, or have a referral agreement with, a qualified social worker or social work agency; and (b) the requirement that the facility maintain an active discharge planning program.

Where continued hospital stay in an institution that has not entered into a "swing-bed" agreement with the Secretary is necessitated by the unavailability of an appropriate long-term care bed in the community, and (i) the hospital's occupancy rate is below 80 percent and (ii) it could obtain a certificate of need, payment would be made at the same rate otherwise payable to a participating "swing-bed" hospital. If the hospital's occupancy rate is 80 percent or above, or it cannot obtain a certificate of need (presumably because there is a need for the hospital's acute care beds), payment would be made,

as under present law, at the hospital rate for such period as it is medically determined the patient requires covered skilled nursing care services and an appropriate bed is temporarily unavailable.

In order to avoid imposing a possible disadvantage on institutions that have established "distinct part" skilled nursing facilities, the Committee's bill provides that the simplified "swing-bed" method of reimbursement would be made available under medicare and medicaid for services furnished in such "distinct part" facilities. The Secretary would approve this alternative reimbursement method where the hospital demonstrates that its use would contribute significantly to efficient and effective administration and would be in the interest of program beneficiaries. Making the simplified reimbursement option available would put institutions with distinct part skilled nursing facilities on an even footing with the other hospitals that will be eligible for "swing-bed" reimbursement under the bill.

COORDINATED AUDITS UNDER THE SOCIAL SECURITY PROGRAM (SECTION 21)

The bill requires common audits of entities participating in programs under titles V (maternal and child health), XVIII (medicare), and XIX (medicaid), of the Social Security Act.

Duplication of identical or similar auditing procedures used for the purpose of determining reimbursement under various Federal programs is costly to both the programs and the entities participating in the programs. In order to eliminate this duplication, the Committee's bill requires that, if an entity provides services reimbursable on a cost-related basis under titles V or XIX, audits of books, accounts, and records of that entity are to be coordinated through common audit procedures with audits performed for the purpose of reimbursement under title XVIII. Where a State declines to participate in such common audits, the Secretary is to reduce payments that would have been made to the State under titles V or XIX by any amount in excess of the amount that would have been apportioned to the State if it had participated in the audit.

CERTIFICATION OF PRIVATE SUPPLEMENTARY HEALTH INSURANCE POLICIES "MEDIGAP" (SECTION 22)

The bill requires the Secretary to establish a certification procedure for health insurance policies offered by private insurance companies to supplement medicare. Under the procedure, which would be effective Januray 1, 1981, companies could submit policies to the Secretary for certification that the policy meets prescribed standards relating to retention ratios, preexisting conditions, cancellation clauses, simplicity of policy language and disclosure of information to potential purchasers. (Policies issued in any State which has implemented a regulatory program that requires compliance with minimum standards comparable to those included in the Committee's bill would be deemed to be certified.)

Under the bill penalties would be provided for: (1) furnishing false or misleading information for the purpose of obtaining certification; and (2) misrepresentation as an agent of the Federal Government for the purpose of selling insurance to supplement medicare. Such acts would be punishable upon conviction by a fine of not more than $25,000

and/or imprisonment for not more than five years. The Secretary would also be required to conduct a comprehensive study of existing State programs regulating insurance designed to supplement medicare and to submit recommendations by July 1, 1981, with respect to appropriate methods for assuming more effective regulation of such insurance.

Hearings conducted by both Houses of Congress have disclosed the existence of significant abuses and problems in the sale of private supplementary health insurance to aged medicare beneficiaries. Among the many problems identified were the dissemination of misinformation about the extent of insurance coverage provided, unethical sales practices, restrictive policy clauses, and complex and confusing policy language. As a result of these disclosures, your Committee believes that a consensus has emerged about the critical need to: (1) eliminate the flagrant abuses resulting from unethical sales practices; (2) develop more effective ways for assuring informed choices by beneficiaries among the range of available private policies; and (3) apply more effective approaches to assuring the development and implementation of acceptable minimum standards for these policies.

The Committee's bill would address these issues in several ways; first, by requiring the Secretary to establish a voluntary certification program under which policies meeting prescribed minimum standards would be certified by the Secretary and appropriate information disseminated to beneficiaries about the selection of a suitable supplementary policy (States would be encouraged to apply their own programs by deeming policies in States with comparable standards to be certified); secondly, by providing criminal penalties for acts involving the furnishing of fraudulent or misleading information for purposes of obtaining the Secretary's certification or of selling policies to beneficiaries; and finally, by requiring the Secretary to undertake a major study of the several current methods used by States to regulate the marketing of private supplementary insurance to the aged and to submit recommendations on further steps that might be taken to assure more effective State or, if necessary, Federal regulation of such insurance. The Secretary would also be required to report annually on the effectiveness of the certification procedure and to include in such reports his recommendation as to the need for continuing the procedure.

Your Committee recognizes that these provisions of the bill do not represent a final solution to the serious problems of abuse in the marketing of private policies for the aged and the inadequacy of the protection afforded by a great many supplementary insurance policies. The Committee believes that additional information on how best to deal with these problems is needed and the Committee expects that the study the Secretary is directed by the bill to make will produce both the necessary data and relevant legislative recommendations. Nevertheless, the Committee believes the voluntary certification program represents a useful preliminary step toward the provision of some consumer protection and advice in the selection of appropriate policies.

The Committee also recognizes the efforts recently made by the National Association of Insurance Commissioners in designing and

urging on States a model regulation for supplementary policies. The Committee's bill would lend support to these efforts by providing for automatic certification for policies issued in States which adopt the NAIC's model regulation. However, the Committee believes that until States take the steps necessary to assure aged beneficiaries the protection they need against deceptive marketing practices and inadequately designed policies there is an appropriate role for the Federal Government.

DEMONSTRATION PROJECTS RELATING TO THE TRAINING OF AFDC RECIPIENTS AS HOME HEALTH AIDES (SECTION 23)

The bill authorizes the Secretary to enter into agreements with up to 12 States, selected at his discretion, for the purpose of conducting demonstration projects for the training and employment of AFDC recipients as homemakers and home health aides. Ninety percent Federal matching would be provided under the States' medicaid programs for the reasonable costs (less any related fees collected) of conducting the projects. The projects would be limited to a maximum of 4 years plus an additional period of up to 6 months for planning and development and a similar period for final evaluation and reporting. The Secretary would be required to submit annual evaluation reports, and a final report on all the projects, to the Congress.

It has been estimated that as many as 40 percent of the aged and disabled now in high cost nursing care facilities do not necessarily have to be there—and would probably not be there if alternative supportive services to maintain them in their own homes were available. At the same time, there are many persons currently on the welfare rolls who, if they received appropriate training, could become gainfully employed members of ancillary health professions. The intent of the bill is to permit the Secretary to undertake several demonstration projects to assess the validity of these assumptions and the potential savings to the medicare and medicaid programs of reduced use of institutional care.

A State participating in the project would be required to establish a formal program, approved by the Secretary, to train participants in the provision of homemaker and home health aide services. The State would provide for the employment of those who complete the training program with public or (by contract) nonprofit private agencies engaged in furnishing such services on a part-time or intermittent basis to aged, disabled or other incapacitated individuals who in the absence of such services might otherwise require institutional care.

AFDC recipients entering such a training program would be considered to be participating in a work incentive program authored under part C of title VI of the Social Security Act. During the first year such an individual is employed under the program, he or she would retain medicaid eligibility and any eligibility he or she had prior to entering the training program for social and supportive services provided under part A of title IV. Federal funding would not be available for the employment of any participant under the project after the participant has been employed for a 3-year period.

REIMBURSEMENT FOR HEALTH MAINTENANCE ORGANIZATIONS (HMO'S) (SECTION 24)

The bill would provide reimbursement for health maintenance organizations on the basis of a prospectively determined per capita amount equal to 95 percent of the cost of providing medicare benefits to beneficiaries outside the HMO. Any difference between the HMO's community rate (adjusted for the higher utilization of the elderly and disabled) and the medicare reimbursement would be returned to medicare beneficiaries in additional benefits.

Under present law, health maintenance organizations may contract for medicare reimbursement on either a cost or risk basis. However, only one HMO has opted to be reimbursed under the existing risk formula. HMO's have generally found the risk reimbursement formula unacceptable because retroactive adjustments are made which take into account the costs actually incurred by the HMO. The new risk formula would provide a prospectively determined per capita payment for each enrollee. Your Committee recognizes that HMO's, in the non-medicare portion of their business, receive a fixed, prospectively determined payment per enrollee which is not related to the amount of care. This payment per enrollee acts as a limit on HMO revenues, creating financial incentives for the organization to control costs and to provide only the least expensive service appropriate to the enrollees' needs. These incentives are passed on to the physician by paying him on a salary basis, providing a bonus or profit sharing arrangment when costs are kept low, or providing other meaningful incentives for him to control costs and utilization.

Under your Committee's bill, the rates of medicare payment under the risk contract would be set at 95 percent of the per capita amount that would be paid by medicare for services provided to an enrolled beneficiary (classified by actuarial factors such as age and sex) by other providers in the geographic area of the HMO. For example, the rate of payment for a 65 year old beneficiary would be lower than the rate for an 85 year old beneficiary.

A second important feature of the bill's risk reimbursement formula requires the HMO to provide to enrolled medicare beneficiaries increased benefits or reduced cost-sharing, to the extent that the medicare reimbursement exceeds the amount an HMO would charge its medicare members if that amount were determined using a community rating system (adjusted for the specific benefits covered by medicare and the utilization characteristics of medicare beneficiaries). This approach would create incentives for medicare beneficiaries to enroll in HMO's and assure that the economies realized through HMO efficiencies, in excess of the HMO's usual profit and other retained funds, accrue to beneficiaries. The HMO would determine what additional benefits, reduced beneficiaries cost sharing or combination of the two are most appropriate for its medicare enrollees. The Secretary would be required to report to the Congress three years after enactment on the type and amount of additional benefits which are being provided. Your Committee's bill also requires the Secretary to study and report to the Congress the causes for beneficiary disenrollment from HMO's under medicare contracts, paying particular attention to the utilization and quality of services provided these benficiaries and their medical condition prior to disenrollment.

The HMO would be required to limit the amount of premium or other payments charged its medicare enrollees to the actuarial equivalent of medicare deductibles and coinsurance that would apply to these beneficiaries were they not enrolled in the HMO. The purchase of any benefits the HMO offers in addition to those covered under the medicare program would be optional on the part of beneficiaries. Your committee believes it would be inappropriate to allow HMO's to require beneficiaries to purchase an additional package of benefits as a prerequisite for enrolling in the HMO. Beneficiaries should have the right to enroll in an HMO solely for the purpose of receiving medicare-covered benefits; there should be no economic barriers since all beneficiaries are entitled to medicare benefits no matter how the program makes them available.

Members of an HMO which has elected to be reimbursed under this new risk formula could not receive medicare payments for services not furnished by or through the HMO; the HMO would be responsible for providing all medicare-covered services to medicare enrollees. However, medicare beneficiaries enrolled in an HMO at the time the new method was first applied to the HMO could choose to continue to seek medical care outside the HMO and be reimbursed by medicare in the current manner unless the Secretary, because of the administrative costs or other administrative burdens involved, required the new method to apply to all members of a particular HMO.

An HMO would be defined as an entity which (i) provides all covered medicare benefits to medicare enrollees and (ii) is organized and operated in the manner prescribed by section 1301(b) and (c) of title XIII of the Public Health Service Act. The HMO would not actually have to be Federally-qualified; however, title XIII of that Act provides a basic set of requirements related to organization and operation which your committee believes should be required of any entity participating as an HMO under medicare—assurance of the capacity to bear potential loss, assurance of a fiscally sound operation, requirements for the accessibility and availability of services, and requirements for the types of contractual arrangements, with accompanying incentives to control utilization, appropriate for an HMO. Your committee believes that since the medicare program will not make payment to beneficiaries for any services provided to the beneficiary outside the HMO, the basic requirements in title XIII are necessary to assure that the HMO is organized in such a way that beneficiaries understand clearly where they can obtain services, all appropriate services are available on a 24-hour a day, seven day a week basis, and the HMO as an entity is organized for the purpose of providing services, rather than merely arranging for payment of uncoordinated services. The requirement of title XIII which specifies a minimum set of benefits an HMO must provide in order to qualify under that title would not be applicable. Your committee believes that this requirement might discourage HMO's from participating in medicare since the benefit package under title XIII is more generous than some HMO's might ordinarily provide.

In order to assure that an HMO makes a genuine effort to enroll medicare beneficiaries, the HMO would be required to have an open enrollment period at least every year during which it accepts medicare beneficiaries up to the limits of its capacity and without restrictions in the order in which they apply for enrollment. This require-

ment is necessary since most HMO's enroll only groups and medicare beneficiaries, in many instances, would be enrolling as individuals; without assurance of open enrollment, such medicare beneficiaries would have no access to the HMO. No HMO, however, would have to accept proportionately more medicare enrollees than are represented in the population in the geographic area served by the HMO.

COORDINATION OF QUALITY ASSURANCE PROGRAMS FOR CLINICAL LABORATORIES (SECTION 25)

The bill directs the Secretary to coordinate the development and application of quality assurance standards with respect to clinical laboratories which participate in medicare and medicaid or which are subject to Federal standards under the Public Health Service Act. In addition, the bill extends to December 31, 1980, the Secretary's authority to conduct a program to determine the proficiency of health care personnel, including clinical laboratory personnel, who do not meet formal educational requirements.

Under present law, separate and overlapping quality assurance programs have been developed by the Secretary for application under the medicare and medicaid programs and under the Clinical Laboratory Improvement Act of 1967 which authorizes the promulgation of quality assurance standards for clinical laboratories engaged in interstate commerce. Your Committee is concerned about this lack of coordination which has given rise to considerable regulatory duplication and administrative inconsistency in the application of standards. Consequently, the bill requires the Secretary to establish a uniform quality assurance program for the certification of clinical laboratories under the Social Security and Public Health Service Acts, and to coordinate the administration of this program so as to assure the uniform and consistent application of standards to the various types of clinical laboratories affected by the statutory authorities under present law. The Committee expects that the Secretary will thoroughly review existing regulations, including those regulations relating to personnel qualifications, and make the changes necessary to conform them to the intent of your Committee's bill. With respect to personnel qualifications, the Committee believes it is essential for the Secretary to make a judgment concerning the correlation of formal regulatory requirements for various types of laboratory personnel and satisfactory laboratory performance and to reflect that judgment, with appropriate explanations, in the regulations.

The Committee believes that proficiency examinations represent an effective mechanism for identifying competent health personnel who may lack the necessary credentials otherwise required under personnel standards contained in medicare's conditions of participation. Consequently, the bill extends the Secretary's authority to conduct such examinations to December 31, 1980.

IV. Cost of Carrying Out the Bill and Effects on the Revenues

The following draft report with information relative to the costs of carrying out the bill was furnished to your Committee by the Congressional Budget Office;

Congressional Budget Office Cost Estimate

November 5, 1979.

1. Bill Number: H.R. 4000.

2. Bill Title: Medicare and Medicaid Amendments of 1979.

3. Bill Status: As ordered reported by the Committee on Ways and Means on October 30, 1979.

5. Bill Purpose: The bill would amend title XI, XVII, and XIX of the Social Security Act with respect to the medicare and medicaid programs.

The bill would make changes in some reimbursement procedures, establish new types of arrangements with providers of services, and make technical and administrative changes in the operation of the Professional Standards Review Program. The bill would also provide for new sanctions against persons found to have engaged in fraudulent practices with respect to services provided medicare or medicaid recipients. Finally, the bill contains a number of provisions that would require special studies or make other technical or administrative changes.

5. Cost estimate:

[By fiscal years, in millions of dollars]

	1980	1981	1982	1983	1984
a. Direct Spending Provisions					
Medicare (function 550):					
Sec. 9. PSRO review of routine hospital admission services and preoperative hospital stays	−22.0	−51.2	−60.2	−71.6	−84.9
Sec. 16. Civil money penalties for medicare and medicaid fraud	−5.0	−10.0	−11.0	−12.0	−13.0
Swing beds	(1)	(1)	(1)	(1)	(1)
Reimbursement for inappropriate hospital services	28.0	−64.0	−73.0	−83.0	−94.0
Sec. 21. Coordinated audits	(1)	(1)	(1)	(1)	(1)
Sec. 24. Reimbursement for health maintenance organizations	0	5.0	25.0	35.0	40.0
Total, medicare outlays	−55.0	−120.2	−119.2	−131.6	−151.9
b. Amounts Subject to Appropriation Action					
Medicaid (function 550):					
Required budget authority	(2)	(2)	(2)	(2)	(2)
Estimated outlays:					
Sec. 9. PSRO review of routine hospital admissions services and preoperative hospital stays	−2.2	−4.9	−5.5	−6.0	−6.6
Sec. 16. Civil money penalty for medicare and medicaid fraud	−7.0	−16.0	−17.0	−19.0	−21.0
Sec. 20. Hospitals providing long-term care services:					
Swing beds	(1)	(1)	(1)	(1)	(1)
Reimbursement for inappropriate hospital services	−8.0	−18.0	−20.0	−23.0	−26.0
Sec. 21. Coordinated audits	(1)	(1)	(1)	(1)	(1)
Sec. 23. Demonstration projects relating to the training of AFDC recipients as home health aides	1.0	−6.0	−29.0	−40.0	−44.0
Total, medicaid outlays	(2)	(2)	(2)	(2)	(2)
AFDC (function 600):					
Required budget authority	0	−.6	−3.0	−3.6	−4.2
Estimated outlays: Sec. 23. Demonstration projects relating to the training of AFDC recipients as home health aides	0	−.6	−3.0	−3.6	−4.2
Summary of outlay impact:					
Direct spending	−55.0	−120.2	−119.2	−131.6	−151.9
Amounts subject to appropriation action	−16.2	−45.5	−74.5	−91.6	−101.8
Total	−71.2	−165.7	−193.7	−223.2	−253.7

[1] Estimate not available.
[2] No totals shown because of unavailability of some estimates.

Portions of the bill would reduce future federal liabilities through a change to an existing entitlement, and therefore could permit subsequent appropriation action to reduce the necessary budget authority for the medicaid and AFDC programs. The figures shown as "Required Budget Authority" represent that amount by which budget authority could be reduced below the level needed in the absence of enactment of H.R. 4000.

6. Basis of estimate: This cost assumes enactment by November 30, 1979. Lack of time precludes a detailed discussion of the basis of estimate for this bill.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by Malcolm Curtis and Eric Wedum.

Estimates submitted to your committee by the Health Care Financing Administration's Office of Financial and Actuarial Analysis (Department of Health, Education and Welfare) are identical to those submitted by the Congressional Budget Office, except that estimates were not submitted by the Department of HEW for section 9 (PSRO review) or with respect to any medicaid expenditures and the additional following estimates were submitted by HEW:

Section	1980	1981	1982	1983	1984
20—Swing beds	−73	−75	−79	−84	−90
21—Coordinated audits	−6	−6	−6	−6	−6

Your committee concurs with all the draft estimates submitted by the Congressional Budget Office and the estimates submitted by the Department of Health, Education and Welfare on sections 20 and 21 of H.R. 4000.

V. Other Matters To Be Discussed Under The House Rules

VOTE OF THE COMMITTEE

Your committee reports that the bill, H.R. 4000, as amended, was ordered favorably reported by a voice vote.

OVERSIGHT FINDINGS

Oversight activities with respect to the performance of professional standards review organizations have been conducted during the past several years by the committee's Subcommittees on Oversight and Health. Hearings that included discussion of the PSRO program, for example, were conducted on June 19 and 22, 1978, and June 18 and 27, 1979. On September 30, 1977, the Health Subcommittee devoted the entire hearing to an examination of the role played by nurses and other nonphysician practitioners in the conduct of PSRO review activities. Many of the issues raised in these hearings, particularly with respect to the membership of PSRO's, have been addressed in the bill.

Additionally, your committee's Health Subcommittee has inquired into the effectiveness of the administration of the program during the course of hearings held in June of this year on medicare issues. Testi-

mony was received with respect to the need for improvements in the operation of the skilled nursing home benefit and the conduct of activities designed to detect and prosecute fraudulent actions with respect to the medicare and medicaid programs. Your committee's bill also addresses many of these issues.

NEW BUDGETARY AUTHORITY AND TAX EXPENDITURES

Your committee states that the changes made in present law by this bill involve no new budgetary authority or new or increased tax expenditures.

OVERSIGHT BY COMMITTEE ON GOVERNMENT OPERATIONS

Your committee advises that no oversight findings or recommendations have been submitted to your committee by the Committee on Government Operations with respect to the subject matter contained in the bill.

INFLATIONARY IMPACT

Your committee states that the changes made in existing law by this bill would not have an inflationary impact on prices and costs in the operation of the national economy.

VI. Section-by-Section Analysis of Bill

Section 1

The first section contains the short title of the bill, "Medicare and Medicaid Amendments of 1979."

Section 2. Expanded membership of professional standards review organizations

Section 2 of the bill amends section 1152(b)(1)(A) of the Social Security Act to provide for membership in a PSRO, at the option of the PSRO, of health care practitioners (other than doctors of medicine or osteopathy) engaged in the practice of their professions in the organization's area who hold independent hospital admitting privileges however, such practitioners may not make final determinations with respect to the professional conduct or services of doctors of medicine or osteopathy. (Doctors of medicine or osteopathy can be PSRO members under present law.)

Section 3. Registered nurse and dentist membership on statewide council advisory group

Section 3 of the bill amends section 1162(a)(1) of the Social Security Act to require the inclusion of at least one registered professional nurse and at least one doctor of dental surgery or dental medicine in the membership of an advisory group to a statewide Professional Standards Review Council.

Section 4. Nonphysician membership on National Professional Standards Review Council

Section 4(a) of the bill amends section 1163(a)(1) of the Social Security Act to provide that the membership of the National Professional Standards Review Council will include (in addition to its

present membership) one doctor of dental surgery or dental medicine, one registered professional nurse, and one other health practitioner other than a doctor of medicine or osteopathy.

Section 4(b) of the bill amends section 1163(a)(2) of the Social Security Act to provide that the terms of no more than five members of the Council shall expire in any year.

Section 4(c) of the bill amends section 1163(a)(3) of the Social Security Act to provide that the Secretary shall periodically designate one of the physician members of the Council to serve as the Council's chairman.

Section 4(d) of the bill amends section 1163(b) of the Social Security Act to provide that physician members of the Council shall consist of physicians of recognized standing and distinction in the appraisal of medicine practice.

Section 4(e) of the bill makes a conforming amendment in section 1173 of the Social Security Act.

Section 4(f) provides that the amendments made by section 4 become effective 180 days after enactment of the bill.

Section 5. Advisory committee to the National Professional Standards Review Council

Section 5(a) of the bill amends section 1163 of the Social Security Act by adding at the end thereof a new subsection (f). The new subsection (f) provides that the National Council shall be advised and assisted in carrying out its functions by an Advisory Committee composed of not less than 7 nor more than 15 members who are representatives of health care practitioners (other than physicians) for whose services payment may be made under the Medicare and Medicaid programs. The new subsection (f) further provides that the Secretary shall by regulations establish the manner in which members of the Advisory Committee are to be selected and the terms of service; and the expenses of the committee shall be considered expenses incurred by the National Council.

Section 5(b) provides that the amendments made by section 5 becom effective no later than 180 days after enactment of the bill.

Section 6. Required activities of professional standards review organizations

Section 6(a) amends section 1154(b) of the Social Security Act to permit a conditionally designated Professional Standards Review Organization to be considered a qualified (i.e. fully designated) organization if it is satisfactorily conducting reviews of health care services provided by or in all hospitals in its area.

Section 6(b) amends section 1155(a)(1) of the Social Security Act to permit the Secretary to specify the extent and the time of the assumption of review responsibilities by each Professional Standards Review Organization.

Section 6(c) amends section 1155(g) of the Social Security Act to delete the requirement that a Professional Standards Review Organization must, if capable, review ambulatory care services within 2 years of becoming fully designated.

Section 6(d) amends section 1155 of the Social Security Act by adding a new subsection (h), which permits the Secretary to designate

another qualified Professional Standards Review to conduct reviews of services for which a designated Professional Standards Review Organization has not assumed review responsibilities.

Section 7. Direct reimbursement for professional standards review of hospital services

Section 7(a) repeals section 1815(b) of the Social Security Act, which permits payment to a hospital provider for utilization review activities conducted by a Professional Standards Review Organization if the hospital has an arrangement with the organization and if the hospital pays the organization for such review activities.

Section 7(b) amends section 1861(w) of the Social Security Act by striking out paragraph (2), relating to the definition of arrangements between a hospital and a Professional Standards Review Organization for the conduct of utilization review activities.

Section 7(c) provides that the amendments made by section 7 apply to utilization review activities conducted after the date of enactment.

Section 8. Consultation by professional standards review organizations with health care practitioners

Section 8(a) amends section 1155(a) of the Social Security Act by adding a new paragraph (8), which requires each Professional Standards Review Organization to consult (in a manner prescribed by the Secretary) with representatives of health care practitioners (other than physicians) and of institutional and noninstitutional providers of health care services, in relation to the Professional Standards Review Organization's responsibility for the review of the professional activities of such practitioners and providers.

Section 8(b) amends section 1162(e) of the Social Security Act to delete the requirement that the Professional Standards Review Organizations in a State which does not have a Statewide Professional Standard Review Council must be advised or assisted by an advisory group of not less than 7 nor more than 11 members who are representatives of health care practitioners, other than physicians.

Section 8(c) provides that the amendments made by section 8 become effective 180 days after the date of enactment.

Section 9. Review of routine hospital admission services and preoperative hospital stays by professional standards review organizations

Section 9(a) amends section 1155(a)(2) of the Social Security Act to authorize each Professional Standards Review Organization to determine, in advance, the medical necessity and appropriateness of any elective admission to a hospital or other health care facility (including admissions occurring on weekends) and any routine diagnostic services furnished in connection with such an admission. Section 9 further amends section 1155(a)(2) to permit the Secretary to direct each such organization to exercise this authority where he finds that the determinations can be made on a timely basis and appropriate procedures will be applied to assure prompt notification of the determinations to providers, physicians, practitioners, and beneficiaries.

Section 10. Study of PSRO norms, standards, and criteria

Section 10 requires the Secretary to conduct, in consultation with the National Professional Standards Review Council, a nationwide

study of the differences in medical criteria and length-of-stay norms utilized by Professional Standards Review Organizations in the various regions of the country and to report the findings and conclusions made with respect to the study to the Congress within one year of the date of enactment.

Section 11. Agreements with skilled nursing facilities

Section 11 amends section 1866 of the Social Security Act to delete the requirement that the term of a provider agreement with a skilled nursing facility must not exceed 12 months (with an optional 2 month extension).

Section 12. Consultative services for skilled nursing facilities

Section 12 amends section 1864(a) of the Social Security Act to repeal the provisions authorizing Medicare reimbursement for consultative services furnished by State agencies to skilled nursing facilities.

Section 13. Study of need for dual participation of skilled nursing facilities

Section 13(a) requires the Secretary to conduct, after appropriate consultation, a study of the availability and need for skilled nursing facility services covered under Part A of title XVIII of the Social Security Act and under State plans approved under title XIX of such Act.

Section 13(b) requires the Secretary to complete this study and submit a report (including any recommendations for administrative or legislative changes), to the Committee on Finance of the Senate and to the Committee on Ways and Means and the Committee on Interstate and Foreign Commerce of the House of Representatives within one year after enactment.

Section 14. Alternative to decertification of skilled nursing facilities out of compliance with conditions of participation

Section 14(a) amends section 1866 of the Social Security Act by adding a new subsection (f), which permits the Secretary to deny payment for services furnished to Medicare and Medicaid beneficiaries after a specified date by a skilled nursing facility out of compliance with the provider conditions of participation if the deficiencies do not immediately jeopardize the health and safety of patients. New subsection (f) further requires the Secretary to provide the facility the opportunity to correct its deficiencies, to provide a hearing for the facility before such denial of payment, and to provide notification to the facility and the public concerning such action.

Section 14(b) amends section 1903 of the Social Security Act, as amended by section 16 of the bill by adding a new paragraph (4) to the new subsection (r) added by section 16. New paragraph (4) requires any order for denial of payment to a skilled nursing facility under section 1866(f) to become effective on the date so specified by the Secretary.

Section 15. Life Safety Code requirements

Section 15 amends section 1861(j)(13) of the Social Security Act to delete the requirement that a skilled nursing facility must meet the 1973 edition of the Life Safety Code of the National Fire Protection

Association, and to provide that such facility must meet applicable provisions of such edition of the Code as is specified in regulations.

Section 16. Civil monetary penalties for medicare and medicaid fraud

Section 16 amends section 1107 of the Social Security Act by adding a new subsection (c). New subsection (c) authorizes the Secretary to assess a civil penalty of not more than $2,000 (plus an assessment for damages of not more than twice the amount claimed) for each claim for reimbursement under Medicare and Medicaid for medical items or services that were not provided, or were provided in violation of Federal or State law or regulation, or were provided in violation of an agreement with the United States or a State agency. In determining the amount of any such penalty or assessment, the Secretary is required to take into account (A) the nature of the claims and the circumstances under which they were presented; (B) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims; and (C) such other matters as justice may require. New subsection (c) further requires the Secretary to give written notice and an opportunity for a hearing on the record, with the right to be represented by counsel, to present witnesses, and to cross-examine, and specifies the right of any person adversely affected by a determination of the Secretary under these provisions to judicial review of the determination in the Court of Appeals. If the penalties and assessments exceed $15,000 within a 2 year period, the provider or individual may request a de novo trial in a District Court.

Section 16 also makes a conforming amendment to section 1903 of the Social Security Act.

Section 17. Exclusion of health care professionals convicted of medicare or medicaid-related crimes

Section 17(a) amends title XI of the Social Security Act by adding a new section 1127.

Subsection (a) of new section 1127 requires the Secretary to bar from participation in the programs established by titles XVIII and XIX of the Social Security Act any physician or other individual who has been convicted of a criminal offense related to either program.

Subsection (b) of new section 1127 specifies the manner in which the Secretary's determination under section 1127 will become effective.

Subsection (c) of new section 1127 specifies the right of any person adversely affected by a determination of the Secretary under section 1127(a) to a hearing on the record and to judicial review of the determination.

Section 17(b) amends section 1862(e) of the Social Security Act to prohibit payment under title XVIII to physicians or other individuals barred, under section 1127, from participation in the program.

Section 17(c) amends section 1902(a)(39) of the Social Security Act to prohibit payment under title XIX to physicians or other individuals barred under section 1127 from participation in the program.

Section 17(d) makes a conforming amendment to section 1902 of the Social Security Act by repealing subsection (g).

Section 18. Requirements concerning reporting of financial interest

Section 18(a) amends section 1124(a)(3)(A)(ii) of the Social Security Act to provide that a disclosing entity is required to report only

those individual interests in mortgages or other obligations equal to at least $25,000 or 5 percent of the entity's total assets.

Section 18(b) amends section 1902(a)(35) to require the State plan under title XIX to provide that any entity receiving payments under such plan complies with the disclosure of ownership and related information requirments of section 1124.

Section 19. Withholding of Federal share of payments to medicaid providers to recover medicare overpayments

Section 19(a) amends the provisions of section 1902(a)(13) of the Social Security Act relating to State plan requirements for payment for inpatient hospital, skilled nursing facility, and intermediate care facility services to prohibit such payment where the State agency is subject to an order under new section 1913, added by subsection (d) of section 19 of the bill.

Sections 19(b) and 19(c) make technical conforming amendments to section 1903, relating to payment to States.

Section 19(d) amends title XIX of the Social Security Act by adding a new section 1913, which permits the Secretary to withhold the Federal share of Medicaid payments to an institution (or person) that participates or has participated in (or has accepted assignment under) Medicare and from which the Secretary has been unable to recover (or determine the amount of) Medicare overpayments. New section 1913 further requires the Secretary to provide notice to the State agency and the provider of such action, and directs him to promulgate regulations to implement this section.

Section 20. Hospital providers of long-term-care services ("swing-beds")

Section 20(a)(1) amends title XVIII of the Social Security Act by adding a new section 1882 entitled "Hospital Providers of Extended Care Services."

New section 1882(a)(1) provides that any hospital (other than a hospital which has in effect a waiver of the 24-hour nursing service requirement imposed by section 1861(a)(5) of the Social Security Act) which has filed an agreement under section 1866 of the Social Security Act (relating to the charges a hospital may make for the medicare deductibles and coinsurance) may (subject to subsection (b) of this new section), enter into an agreement with the Secretary under which its inpatient facilities may be used to furnish services of the type which, if furnished by a skilled nursing facility, would constitute post-hospital extended care services.

New section 1882(a)(2)(A) and (B) provides that, notwithstanding any other provision of title XVIII of the Social Security Act, payment for services furnished under an agreement entered into under this new section shall be based on the reasonable cost of routine services (as determined under clause (ii) of paragraph (B)) and the reasonable cost of ancillary services (as determined under clause (iii) of paragraph (B)). Clause (ii) of paragraph (B) provides that the reasonable cost of routine services furnished during any calendar year is equal to the product of the number of patient days during the year for which the services were furnished and the average reasonable cost per patient day (such average being the average rate per patient day

paid for routine services during the previous calendar year under title XIX of the Social Security Act to skilled nursing facilities located in the State in which the hospital is located and which have agreements under sec. 1902(a)(28) of the Social Security Act). Clause (iii) of paragraph (B) provides that the reasonable cost of ancillary services shall be determined in the same manner as for inpatient hospital services.

New section 1882(b) provides that the Secretary may not enter into an agreement under this section unless the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under sec. 1521 of the Public Health Service Act).

New section 1882(c) provides that an agreement with a hospital under this section shall, except as otherwise provided by the Secretary in regulations, be subject to termination on the same conditions and impose the same duties, responsibilities, conditions, and limitations as agreements entered into under section 1866 of the Social Security Act. A hospital whose agreement under this section has been terminated is not eligible to enter a new agreement under this section for at least 2 years from the termination date.

New section 1882(d) provides that payment may be made to a hospital under an agreement entered into under this section for extended care services only if payment would have been made for such services if they had been furnished by a skilled nursing facility; and individuals on whose behalf such payments are made shall be deemed, for purposes of title XVIII of the Social Security Act, to have received posthospital extended care services.

New section 1882(e) provides that during the period a hospital has in effect an agreement under this section, the total reimbursement received for routine services from all classes of long-term care patients shall be subtracted from the hospital's total routine costs before calculations are made to determine medicare's reimbursement for routine hospital services.

New section 1882(f) requires a hospital which enters into an agreement with the Secretary under section 1883 to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1861(j)(15). Services furnished by such a hospital, which would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility, are subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate.

New section 1882(g) requires the Secretary to prescribe an alternative method for determining the reasonable cost of post-hospital extended care services furnished in a distinct part of a hospital certified as a skilled nursing facility under section 1861(j) that is the same "swing-bed" method provided in new section 1882.

Section 20(a)(2) amends section 1861(v)(1) by adding a new subparagraph (G), relating to inpatient services that would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility.

New subparagraph (G) requires payment for such services to be computed as provided in new section 1882(a), if the following conditions are met: (1) such services are furnished on the basis of a determination by a Professional Standards Review Organization (or other authorized review organization) that post-hospital extended care services are medically necessary and such services are not otherwise available; (2) such hospital has had, during the immediately preceding calendar year, an average daily occupancy rate of less than 80 percent; and (3) such hospital could be granted a certificate of need for the provision of long-term services from the designated State health planning and developing agency for the State in which the hospital is located. New subparagraph (G) further provides that where such payment is made, the individual who is furnished such services will be deemed, for purposes of title XVIII, to have received post hospital extended care services. In addition, the Secretary is required to submit to the Congress, within 3 years after the date of enactment, a report evaluating the program established by the amendment made by section 20(a)(1) of the bill.

Section 20(b) of the bill amends title XIX of the Social Security Act by adding a new section 1914, entitled "Hospital Providers of Skilled Nursing and Intermediate Care Services." New section 1914 conforms Medicaid reimbursement for skilled nursing facility services and intermediate care facility services furnished by a hospital (including a long-term care provided in a distinct part of the hospital) with an agreement under new section 1882 to the "swing-bed" payment provisions of that section.

Section 20(c) provides that the amendments made by section 20 become effective on the date on which final implementing regulations are first issued; and provides further that those regulations must be issued not later than the first day of the sixth calendar month following the month in which the bill is enacted.

Section 21. Coordinated audits under the Social Security Act

Section 21(a) of the bill amends title XI of the Social Security Act by adding at the end thereof a new section 1128 entitled "Coordinated Audits." The new section 1128 provides that if an entity furnishes services that are reimbursable on a cost-related basis under titles V or XIX, as well as under title XVIII of the Social Security Act, the Secretary shall require, as a condition of payment to any State under titles V or XIX with respect to administrative costs incurred in the performance of audits of that entity, that these audits be coordinated with audits performed for purposes of title XVIII of such act. The Secretary shall specify the method for apportioning the cost of coordinated audits among the programs established under these titles. Where a State has declined to participate in a common audit with respect to titles V or XIX, the Secretary shall reduce the payments otherwise due the State under such titles by an amount be estimates exceeds the amount that would have been apportioned to the State (for the expenses of the State incurred in the common audit) if it had participated in the common audit.

Section 21(b)(1) of the bill amends section 1902(a) of the Social Security Act by adding a new paragraph (41) which makes conforming amendments in title XIX of the Social Security Act with respect

to the performance of common audits of entities also providing services under title XVIII of the Social Security Act and the apportionment of the cost for the performance of such common audits.

Section 21(b)(2) of the bill provides that the new paragraph (41) shall apply to medical assistance provided under a State plan approved under title XIX of the Social Security Act, on or after the first day of the first calendar quarter beginning more than 30 days after the date of enactment of the bill.

Section 21(c)(1) of the bill amends section 505(a) of the Social Security Act by adding a new paragraph (15) which makes conforming amendments in title V of the Social Security Act with respect to the performance of common audits of entities also providing services under title XVIII of such act and the apportionment of the cost for the performance of such common audits.

Section 21(c)(2) of the bill provides that the new paragraph (15) shall apply to services provided, under a State plan approved under title V of the Social Security Act, on or after the first day of the first calendar quarter beginning more than 30 days after the date of enactment of the bill.

Section 21(d) of the bill requires the Secretary to report to the Congress, no later than July 1, 1980, on the actions he has taken to: (1) coordinate the conduct of institutional audits and inspections required under the programs funded under titles V, XVIII, or XIX of the Social Security Act; and (2) coordinate such audits and inspections with those conducted by other cost payers. The Secretary is to include in this report such legislative recommendations as he deems appropriate to assure maximum feasible coordination of such institutional audits and inspections.

Section 22. Voluntary certification of private supplementary policies ("MEDIGAP")

Section 22 amends title XI of the Social Security Act by adding a new section 1174, entitled "Voluntary Certification of Supplementary Health Insurance Policies."

Subsection (a) of the new section 1174 requires the Secretary to establish, no later than January 1, 1981, a procedure whereby health insurance policies offered by private insurers in supplementation of benefits provided under title XVIII of the Social Security Act may be certified as meeting minimum standards with respect to adequacy of coverage, reasonableness of premium charge, and disclosure of information to the insured. The procedure so established must provide an opportunity for any insurer to submit any such policy to the Secretary for his examination and certification, which remains in effect if a notarized statement is filed no later than December 31 of each year stating that the policy continues to meet the standards set forth in section 1174 and if additional supporting data is submitted to the Secretary. A ceritfication emblem will be authorized to be printed on certified policies. Subsection (a) also requires the Secretary to provide each State insurance commissioner with a list of all the policies which have received his certification.

Subsection (b) of new section 1174 prohibits the Secretary from certifying under section 1174 any policy unless he finds that such policy—

(1) supplements both Part A and Part B of title XVIII;

(2) is written in simplified language which can be understood by purchasers;

(3) does not limit or preclude liability under the policy for a period longer than 6 months because of a health condition existing before the policy is effective;

(4) contains a prominently displayed "no loss cancellation clause" enabling the insured to return the policy within 30 days of the date of sale without financial loss;

(5) can be expected to return to policyholders in the form of benefits such percentage of the amount of premiums collected as the Secretary finds reasonable, except that such percentage may not be less than 75 percent for group policies and 60 percent for individual policies; and

(6) contains a written statement for prospective purchasers of such information as the Secretary prescribes relating to the policy's premium, coverage, renewability and coinsurance provisions, and the identification of the insurer and its agent.

Subsection (c) of new section 1174 specifies that any supplementary health insurance policy issued in any State which has established a regulatory minimum standards program for such policies with standards equal to or more stringent than those under section 1174(b) is deemed to meet the standards set forth in 1174(b).

Subsection (d)(1) of new section 1174 provides that a person making a false statement with respect to the compliance of any policy with the standards set forth in section 1174(b) or in the implementing regulations is guilty of a felony and subject to a fine of not more than $25,000 or imprisonment for not more than 5 years or both.

Subsection (d)(2) provides that a person misrepresenting that he is acting for any program of health insurance established by Federal law for the purpose of selling insurance or obtaining articles of value is guilty of a felony and subject to a fine of not more than $25,000 or imprisonment for not more than 5 years, or both.

Subsection (e) of new section 1174 requires the Secretary to make available to all persons entitled to benefits under title XVIII (and to the extent feasible, persons about to become so entitled) information to permit them to evaluate the value of supplementary policies and the relationship of any such policies to Medicare benefits.

Subsection (f)(1) of new section 1174 requires the Secretary to conduct, in consultation with regulatory agencies, the National Association of Insurance Commissioners, private insurers, and organizations representing consumers and the aged, a study of the effectiveness of various State approaches to the regulation of private supplementary health insurance in achieving certain specified goals. The Secretary is required to submit to the Congress, by July 1, 1981, a report on this study, including recommendations relating to appropriate methods for assuring more effective regulation of such supplementary insurance policies.

Subsection (f)(2) of new section 1174 requires the Secretary to submit to the Congress on January 1 of each year (beginning in 1982) a report evaluating the effectiveness of the certification procedure established by section 1174.

Subsection (g) of new section 1174 authorizes the Secretary to prescribe such regulations as may be necessary for the effective, efficient and equitable administration of the certification procedure established under section 1174.

Section 23. Demonstration projects relating to the training of AFDC recipients as home health aides

Section 23(a) permits the Secretary to enter into agreements with States, selected at his discretion, for the purpose of conducting demonstration projects for the training and employment of eligible participants as homemakers or home health aides, who are to provide authorized services to elderly or disabled individuals, or other needy individuals.

Section 23(b) defines for purposes of this section the term "eligible participant" as an individual who has voluntarily applied for participation and who, at the time such individual enters the demonstration project, has been eligible for financial assistance under a State plan approved under Part A of title IV of the Social Security Act and has continuously received such financial assistance during the immediately preceding 90-day period and who, within such 90-day period, had not been employed as a homemaker or home health aide.

Section 23(c)(1) requires the Secretary to enter into agreements under section 23 with no more than 12 States and requires that priority be given to States which have demonstrated interest in providing such homemaker or home health aid services.

Section 23(c)(2) permits a State to apply to enter into an agreement under section 23 in such manner and at such time as the Secretary prescribe.

Section 23(c)(3) requires any State entering into an agreement with the Secretary under section 23 to:

(*a*) provide that the demonstration project be administered by a State health services agency designated for this purpose by the Governor;

(*b*) provide that the agency so designated must arrange for coordinating its activities under the agreement with activities of other State agencies having related responsibilities;

(*c*) establish a formal training program, which meets such standards as the Secretary may establish, to assure the adequacy of such program to prepare eligible participants to provide part-time and intermittent services to individuals who are elderly, disabled, or otherwise in need of such services;

(*d*) provide for the full-time employment of those eligible participants who successfully complete the training program with one or more public agencies (or, by contract, with private bona fide nonprofit agencies) as homemakers or home health aides rendering authorized services under appropriate supervision at wage levels comparable to the prevailing wage levels in the area for similar work;

(*e*) provide that such services must be made available without regard to income of the individual requiring such services, but that a reasonable fee will be charged for services provided to individuals who have income in excess of 200 percent of the needs

standard in the State under the State plan approved under Part A of title IV of the Social Security Act for a household of the same size as the individual's household;

(*f*) provide for a system of continuing independent professional review by an appropriate panel to assure that services are provided only to individuals reasonably determined to be in need of such supportive services;

(*g*) provide for evaluation of the project and review of all agencies providing services under the project;

(*h*) submit periodic reports to the Secretary as he may require; and

(*i*) meet such other requirements as the Secretary may establish for the proper and efficient implementation of the project.

Section 23(c)(4) provides that the number of participants in any project must not exceed that number which the Secretary determines to be reasonable, based upon the capability of the agencies involved.

Section 23(c)(5) requires any contract with a private bona fide nonprofit agency entered into to provide a training program under the project must provide for reasonable reimbursement of such agencies for services.

Section 23(c)(6) specifies, for purposes of section 23, that a facility of the Veterans' Administration must, at the request of the Administrator of Veterans' Affairs, be considered to be a public agency. In the case of any such facility, of the costs determined under section 23 which are attributable to such facility, 90 percent must be paid by the State and 10 percent by the Veterans' Administration.

Section 23(d)(1) defines authorized homemaker and home health aide services to include part-time or intermittent—

(*a*) personal care;

(*b*) assisting patients having limited mobility;

(*c*) feeding and diet assistance;

(*d*) home mangement, housekeeping, and shopping;

(*e*) health-oriented record keeping;

(*f*) family planning services; and

(*g*) simple procedures for identifying potential health problems.

Section 23(d)(2) specifies that such authorized services do not include any services performed in an institution, or any services more efficiently provided in an institution.

Section 23(e)(1) requires the Secretary to pay, under agreements entered into under section 23 with the State agency designated by the Governor, 90 percent of the reasonable cost incurred (less the Federal share of any related fees collected) by such State in carrying out the demonstration project.

Section 23(e)(2) limits the demonstration projects to a maximum duration of 4 years, plus an additional period of up to 6 months for planning and development, and up to 6 months for final evaluation and reporting and prohibits Federal funding for the employment of any eligible participant under the project after such participant has been employed for a period of 3 years.

Section 23(f) provides that for purposes of title IV of the Social Security Act, any eligible participant taking part in a training pro-

gram under such a project is to be participating in a work incentive program established by Part C of such title.

Section 23(g) continues the eligibility of eligible participants employed in the demonstration project for medical assistance under title XIX of the Social Security Act, and any eligibility for social and supportive services provided under Part A of title IV of such Act, for the first year (and such succeeding period as the State may specify) of such employment.

Section 23(h) requires the Secretary to submit annual reports to the Congress evaluating the demonstration projects carried out under section 23 and a final report to the Congress not less than 6 months after he has received the final reports from all States participating in such projects.

Section 23(i) authorizes the Secretary to waive such requirements, including formal solicitation and approval requirements, as will further expeditious and effective implementation of these provisions.

Section 24. Reimbursement for health maintenance organizations

Section 24(a) revises the provisions of section 1876 of the Social Security Act, entitled "Payments to Health Maintenance Organizations."

Subsection (a) of revised section 1876 requires the Secretary to determine annually a per capita payment rate for each class (based on factors such as age, sex, institutional status, disability status, and place of residence) of Medicare beneficiaries equal to 95 percent of the adjusted average per capita cost for that class. The term "adjusted average per capita cost" is defined as the average per capita amount that the Secretary estimates in advance would be payable in any contract year for covered services if the services were to be furnished by other than a health maintenance organization.

The Secretary is required to make advance monthly payments from the appropriate trust funds in accordance with hte established rate to a health maintenance organization for Medicare enrollees.

Subsection (b) of revised section 1876 defines, for Medicare purposes, the term "health maintenance organization" as a legal entity which provides services in the manner prescribed by section 1301(b) of the Public Health Service Act is organized and operated in the manner prescribed by section 1301(c) of the Public Health Service Act, with certain specified exceptions. The organization is required to have an open enrollment period of reasonable duration at least every year during which it accepts up to the limits of its capacity and without restrictions (except as authorized in regulations) individuals who are eligible to enroll under revised section 1976(d) in the order in which they apply for enrollment, unless to do so would result in failure to meet the requirements of revised section 1876(h) or would result in the enrollment of enrollees substantially nonrepresentative of the population in the geographic area served by such organization. The Secretary is directed to administer section 1876 through the Administrator of the Health Care Financing Administration except that the determination of whether an organization is a health maintenance organization for Medicare purposes is required to be integrated with the administration of title XIII of thePublic Health Services Act.

Subsection (c) of revised section 1786 provides that if an individual is enrolled in accordance with this section 1876 with a health maintenance organization, only the health maintenance organization is entitled to receive Medicare payments for services furnished to the indvidual.

Subsection (d) of revised section 1876 establishes the eligibility of every individual entitled to benefits under Part A and enrolled under Part B or enrolled under Part B (other than an individual medically determined to have end-stage renal disease) to enroll under section 1876 with any health maintenance organization with a contract with the Secretary and which serves the geographic area in which the individual resides.

Subsection (e) of revised section 1876 permits an enrolled individual to terminate his enrollment with the health maintenance organization as of the beginning of the first calendar month following a full calendar month after the request for termination is made, and authorizes the Secretary to prescribe procedures related to enrollment and the dissemination of information to beneficiaries.

Subsection (f) of revised section 1876 specifies the right of a beneficiary who believes he has been underserved or overcharged by the health maintenance organization to a hearing before the Secretary if the amount in controversy is $100 or more. Beneficiaries and health maintenance organizations are entitled to judicial review of the Secretary's determination if the amount in controversy is $1,000 or more.

Subsection (g)(1) of revised section 1876 prohibits health maintenance organizations from charging beneficiaries more than the actuarial value of the Medicare deductibles and coinsurance for services covered under Medicare.

Subsection (g)(2) of revised section 1876 requires the election by enrolled beneficiaries of coverage additional to that provided by Medicare to be optional, and specifies that the charge to beneficiaries for such additional coverage cannot exceed the adjusted community rate for the services.

Subsection (g)(3) of revised section 1876 defines, for purposes of section 1876, the term "adjusted community rate" for a service as the rate of payment for that service which the Secretary annually estimates would apply to an beneficiary enrolled with a health maintenance organization if the rate of payment were determined under a "community rating system" (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), but adjusted for differences between the utilization characteristics of beneficiaries and those of the other members of the organization.

Subsection (g)(4) of revised section 1876 permits the health maintenance organization (in the case of services for which the beneficiary is entitled to benefits under a workman's compensation law or under an automobile insurance policy) to charge—

(*a*) the insurance carrier, employer, or other entity which under such law or policy is to pay for the provisions of such services, or

(*b*) the beneficiary to the extent that he has been paid under such law or policy for such services.

Subsection (h) of revised section 1876 requires the health maintenance organization to have an enrolled membership at least half of which consists of individuals who are not entitled to benefits under

title XVIII or title XIX. The Secretary is permitted to modify or waive this requirement in circumstances that warrant special consideration provided that the health maintenance organization will not have, for the duration of its contract, an enrolled membership of which one-half or more are individuals entitled to benefits under title XVIII.

Subsection (i)(1) of revised section 1876 permits the Secretary to enter into a contract with any health maintenance organization that meets the definition contained in subsection (b)(1) of revised section 1876.

Subsection (i)(2) of revised section 1876 requires each contract with a health maintenance organization to provide that if the adjusted community rate for enrolled individuals with Medicare coverage (Parts A and B or Part B only) is less than the average per capita rates of payment made under section 1876 at the beginning of the contract period, the organization must provide to such enrollees additional benefits which are selected by the organization. These additioanl benefits must equal or exceed the value of the difference between the average per capita payment and the adjusted community rate.

Subsection (i)(3) of revised section 1876 requires these additional benefits to be either (A) the reduction of the premium rate or other charges made with respect to services furnished by the organization to individuals enrolled under section 1876, or (B) the provision of additional benefits described as basic or supplemental health services in section 1302 of the Public Health Service Act.

Subsection (i)(4) of revised section 1876 authorized the Secretary to require a health maintenance organization to provide these additional benefits in the next contract period to the extent they were not provided in the period to which they apply.

Subsection (i)(5) of revised section 1876 specifies terms of the contract between the Secretary and the health maintenance organization.

Subsection (i)(6) of revised section 1876 requires the effective date of any contract to be specified in the contract.

Subsection (i)(7) of revised section 1876 requires each contract to include certain provisions relating to (A) the right of the Secretary to evaluate the services provided by the health maintenance organization and to inspect the organization's books and records; (B) notification to beneficiaries of contract termination; and (C) compliance with financial disclosure provisions of title XIII of the Public Health Service Act.

Subsection (i)(8) of revised section 1876 prohibits the Secretary, except under special circumstances, from contracting with a health maintenance organization under section 1876 if the organization had, within the last 5 years, requested the termination of a previous section 1876 contract.

Subsection (i)(9) of revised section 1876 provides that the contract authority granted to the Secretary under subsection (i) may be exercised without regard to conflicting provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States.

Section 24(b) of the bill amends section 1861(s)(2) of the Social Security Act by adding a new subparagraph (G), which covers under Part B services furnished by a physician assistant or nurse practi-

tioner to beneficiaries enrolled in a health maintenance organization with a contract under section 1876.

Section 24(c) of the bill amends section 1861 of the Social Security Act to make technical conforming changes to the definition of the terms "physician assistant" and "nurse practitioner."

Section 24(d) of the bill specifies the effective date of the amendments made by section 24. These amendments generally apply to services furnished on or after the first day of the thirteenth calendar month which begins after the date of enactment of the bill, or earlier if a health maintenance organization to requests and the Secretary agrees. These amendments do not apply to beneficiaries who are enrolled with a health maintenance organization at the time it enters into a contract under revised section 1876 unless they request otherwise or the Secretary, because of the administrative costs or other burdens involved, requires the amendments to be applied. The amendments also do not apply (unless the organization requests otherwise) for 5 years following enactment in the case of a health maintenance organization which had a risk-sharing contract with the Secretary under the existing provisions of section 1876 immediately before the date of enactment.

Section 24(e) of the bill requires the Secretary to conduct a study of the additional benefits selected by health maintenance organizations pursuant to section 1876(i)(2) of the Social Security Act, as added by section 24(a) of the bill. The Secretary is required to report to the Congress within 24 months of the date of the enactment of the bill with respect to the findings and conclusions made as a result of the study.

Section 24(f) requires the Secretary to conduct a study evaluating the extent of, and reasons for, the termination by Medicare beneficiaries of their memberships in health maintenance organizations. The Secretary is required to submit an interim report to the Congress within 2 years of the date of the enactment of the bill, and a final report within 5 years of the date of enactment containing findings and conclusions made as a result of the study.

Section 25. Quality assurance programs for clinical laboratories

Section 25 amends section 1123(a) of the Social Security Act to extend until December 31, 1980 the program conducted by the Secretary to determine the proficiency of individuals who do not otherwise meet formal qualifications criteria to perform the duties of certain health care personnel.

Section 25 further amends title XI of the Social Security Act by adding a new section 1128, entitled "Coordination of Quality Assurance Programs For Clinical Laboratories."

Subsection (a) of new section 1128 requires the Secretary to provide, consistent with the authority provided under sections 1861(e) and 1861(s) of the Social Security Act (for the certification of clinical laboratories) and the authority provided under section 353 of the Public Health Service Act (for the licensure of clinical laboratories engaged in interstate commerce), for the application of uniform quality assurance standards to classes of clinical laboratories. In promulgating such standards, the Secretary is required to include such requirements for personnel in clinical laboratories as he deter-

mines are necessary to assure the consistent performance by clinical laboratories of reliable, accurate laboratory tests and other procedures and services performed by clinical laboratories.

Subsection (b) of new section 1128 requires the Secretary to take such administrative actions as are necessary to provide for uniform and consistent application of such quality assurance standards to such clinical laboratories and requires him to report periodically to the Congress on such actions and their effectiveness in accomplishing the purpose of section 1128.

VII. Changes in Existing Law Made by the Bill as Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Social Security Act

* * * * * * *

TITLE V—MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

* * * * * * *

APPROVAL OF STATE PLANS

Sec. 505. (a) In order to be entitled to payments from allotments under section 502, a State must have a State plan for maternal and child health services and services for crippled children which—

(1) * * *

* * * * * * *

(14) provides that acceptance of family planning services provided under the plan shall be voluntary on the part of the individual to whom such services are offered and shall not be a prerequisite to eligibility for or the receipt of any service under the plan; [and]

(15) provides—

(A) that the State health agency, or other appropriates State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of services under the plan and, where applicable, for providing guidance with respect thereto to the other State agency referred to in paragraph (2); and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform the function of determining whether institutions and agencies meet the re-

quirements for participation in the program under the plan under this title[.] *; and*

(16) provides (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that under part A of title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of the proportion of costs of each such common audit of such an entity equal to the proportion of total program benefit payments to the entity (by all third-party payers participating in the common audit for the period being audited) which are payments under this title.

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TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

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Part A—General Provisions

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[Penalty for Fraud]

Sec. 1107. (a) * * *

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"(c) (1) Any person (including an organization, agency, or other entity) who presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency, a claim (as defined in paragraph (11) (B)) that the Secretary determines is for a medical or other item or service—

(A) that such person knows or has reason to know was not provided as claimed, or

(B) that was provided in violation of Federal or State law or regulation, or

(C) that was provided in violation of an agreement between such person and the United States or a State agency,

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $2,000 for each such item or service. In addition, such a person shall be subject to an assessment of not more than twice the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim.

(2) The Secretary shall not make a determination adverse to any person under paragraph (1) until such person has been given written notice and an opportunity for a hearing on the record at which he is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against him.

(3) In determining the amount of any penalty assessed pursuant to paragraph (1) of this subsection, the Secretary shall take into account

(A) the nature of the claims and the circumstances under which they were presented, (B) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims, and (C) such other matters as justice may require.

(4)(A) Except as provided in subparagraph (B), any person adversely affected by a determination of the Secretary under this subsection may obtain a review of such determination in the United States Court of Appeals for the circuit in which the person resides, or in which the claim was presented, by filing in such court within sixty days following notification to the person of the Secretary's final determination a written petition praying that the determination be modified or set aside. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, and thereupon the Secretary shall file in the court the record in the proceeding as provided in section 2112 of title 28, United States Code. Upon such filing, the court shall have jurisdiction of the proceeding and of the question determined therein, and shall have the power to make and enter upon the pleadings, testimony, and proceedings set forth in such record a decree affirming, modifying, remanding for further consideration, or setting aside, in whole or in part, the determination of the Secretary and enforcing the same to the extent that such order is affirmed or modified. No objection that has not been urged before the Secretary shall be considered by the court, unless the failure or neglect to urge such objection shall be excused because of extraordinary circumstances. The findings of the Secretary with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive. If any party shall apply to the court for leave to adduce additional evidence and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the hearing before the Secretary, the court may order such additional evidence to be taken before the Secretary and to be made a part of the record. The Secretary may modify his findings as to the facts, or make new findings, by reason of additional evidence so taken and filed, and he shall file such modified or new findings, which findings with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive, and his recommendations, if any, for the modification or setting aside of his original order. Upon the filing of the record with it, the jurisdiction of the court shall be exclusive and its judgment and decree shall be final, except that the same shall be subject to review by the Supreme Court of the United States, as provided in section 1254 of title 28, United States Code.

(B) In any case in which the penalties and assessments imposed by the Secretary under this subsection to any person exceed $15,000 with respect to—

(i) services or items furnished during a two-year period, or

(ii) in the case of providers, reimbursement on a cost or cost-related basis for cost reports filed for any two consecutive cost reporting periods,

such person may obtain a review of such penalties and assessments in the appropriate United States district court by filing in such court, within sixty days following notification to the person of the Secre-

tary's final determination with respect to the most recent imposition of such penalty or assessment, a written petition praying that such penalties and assessments be modified or set aside. Such court shall make a de novo determination with respect to all of the facts and conclusions of law under consideration.

(5) Civil penalties and assessments imposed under this subsection may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in United States district court for the district where the claim was presented, or where the claimant resides, as determined by the Secretary. Amounts recovered shall be paid to the Secretary, and disposed of as follows: (A) a portion of amounts recovered arising out of a claim under title XIX shall be paid to the State agency, as provided under paragraph (7); (B) such portion of amounts recovered as is determined to have been paid out of the trust funds under sections 1817 and 1841 shall be repaid to such trust funds; and (C) the remainder shall be deposited as miscellaneous receipts of the Treasury of the United States. The amount of such penalty, when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States or a State agency to the person against whom the penalty has been assessed.

(6) A determination by the Secretary to assess a penalty under paragraph (1) of this subsection shall be final upon the expiration of the sixty day period referred to in paragraph (4) unless the person against whom the penalty has been assessed files an appeal as provided in that paragraph. Matters that were raised or that could have been raised in a hearing before the Secretary or in an appeal pursuant to paragraph (4) may not be raised as a defense to a civil action by the United States to collect a penalty or damages assessed under this subsection.

(7) In the case of such a penalty or damages recovered by the United States arising out of a claim filed under title XIX of this act, the State agency shall be reimbursed an amount bearing the same ratio to the sum recovered as the amount paid by the State agency for such claim bears to the total payment for such claim.

(8)(A) The Secretary may enter into an agreement with any person against whom a penalty has been assessed under this subsection whereby such person will consent not to claim payment under title XVIII or a State plan under title XIX for any item or service provided for a period of time not to exceed two years.

(B) The Secretary may refuse to make any further payment under title XVIII of this act, or order a State agency to deny any further payment under title XIX of this act, to any person with respect to whom a final determination has been made to assess a penalty under this subsection, for any item or service rendered during a period of not more than two years from the date upon which such determination became final. If the Secretary intends to exercise the authority in this subparagraph, he shall give written notice thereof to such person and to the single State agency (referred to in section 1902 (a)(5)) of each State which he has reason to believe does or may use the services of such person in providing medical assistance under title XIX of the act, and shall give to such person an opportunity for a

hearing on the record at which he is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against him.

(9) Whenever a final determination to impose a penalty is made by the Secretary under this subsection, he shall notify the appropriate State or local medical agency or organization, an appropriate Professional Standards Review Organization, and the cognizant State or local licensing agency or organization (including the agency specified in section 1864(a) and 1902(a)(33)) that such a penalty has been imposed and the reasons therefor.

(10) The Secretary shall initiate a proceeding under this subsection only as authorized by the Attorney General pursuant to procedures agreed upon by them.

(11) For the purposes of this subsection—

(A) the term "State agency" means the agency established or designated pursuant to section 1902(a)(5) of this Act to administer or supervise the administration of the State plan under title XIX of this Act;

(B) the term "claim" means a claim submitted by (i) a provider of services or other person, agency, or organization that furnishes services under title XVIII of this Act, or (ii) a person, agency, or organization that provides medical assistance under title XIX of this Act against the United States or a State agency for payment for health care servicesu nder title XVIII or XIX of this Act;

(C) the term "item or service" means (i) a particular item, device, medical supply, or service claimed to have been provided to a patient and listed in an itemized claim for payment, or (ii) in the case of a claim based on annual costs, any entry in the annual cost report, books of account or other document supporting such claim; and

(D) the term "agency of the United States" includes any contractor acting as a fiscal intermediary, carrier, or fiscal agent or any other claims processing agent for a health insurance or medical services program under title XVIII or XIX of this Act.

* * * * * * *

PROGRAM FOR DETERMINING QUALIFICATIONS FOR CERTAIN HEALTH CARE PERSONNEL

SEC. 1123. (a) The Secretary, in carrying out his functions relating to the qualifications for health care personnel under title XVIII, shall develop (in consultation with appropriate professional health organizations and State health and licensure agencies) and conduct (in conjunction with State health and licensure agencies) until December 31, [1977,] *1980*, a program designed to determine the proficiency of individuals (who do not otherwise meet the formal educational, professional membership, or other specific criteria established for determining the qualifications of practical nurses, therapists, laboratory technicians, and technologists, and cytotechnologists, X-ray technicians, psychiatric technicians, or other health care technicians and technologists) to perform the duties and functions of practical nurses,

therapists, laboratory technicians, technologists, and cytotechnologists, X-ray technicians, psychiatric technicians, or other health care technicians and technologists. Such program shall include (but not be limited to) the employment of procedures for the formal testing of the proficiency of individuals. In the conduct of such program, no individual who otherwise meets the proficiency requirements for any health care specialty shall be denied a satisfactory proficiency rating solely because of his failure to meet formal educational or professional membership requirements.

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DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION

SEC. 1124. (a) (1) * * *

* * * * * * *

(3) As used in this section, the term "person with an ownership or control interest" means, with respect to an entity, a person who—

(A) (i) has directly or indirectly (as determined by the Secretary in regulations) an ownership interest of 5 per centum or more in the entity; or

[(ii) is the owner (in whole or in part) of an interest of 5 per centum or more in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof; or]

(ii) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to $25,000 or 5 per centum of the total property and assets of the entity; or

* * * * * * *

EXCLUSION OF CERTAIN INDIVIDUALS CONVICTED OF MEDICARE- OR MEDICAID-RELATED CRIMES

SEC. 1127. (a) Whenever the Secretary determines that a physician or other individual has been convicted (on or after October 25, 1977, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such individual's participation in the delivery of medical care or services under title XVIII or title XIX, the Secretary—

(1) shall bar from participation in the program under title XVIII, for such period as he may deem appropriate, each such individual otherwise eligible to participate in such program;

(2) (A) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX, of the fact and circumstances of such determination, and (except as provided in subparagraph (B)) require each such agency to bar such individual from participation in such program for such period as he shall specify, which in the case of an individual specified in paragraph (1) shall be the period established pursuant to paragraph (1);

(B) may waive the requirement under subparagraph (A) to bar an individual from participation in a State plan program under title XIX, where he receives and approves a request for such a waiver with respect to that individual from the State agency administering or supervising the administration of such plan; and

(3) shall promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such individual of the fact and circumstances of such determination, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General fully and currently informed with respect to any actions taken in response to such request.

(b) A determination made by the Secretary under this section shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, post-hospital extended care services, and home health services furnished under title XVIII, such determination shall be effective in the manner provided in paragraphs (3) and (4) of section 1866(b) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(c) Any person who is the subject of an adverse determination made by the Secretary under subsection (a) shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

COORDINATED AUDITS

SEC. 1128. If an entity provides services reimbursable on a cost-related basis under title V or XIX, as well as services reimbursable on such a basis under title XVIII, the Secretary shall require, as a condition for payment to any State under title V or XIX with respect to administrative costs incurred in the performance of audits of the books, accounts, and records of that entity, that these audits be coordinated through common audit procedures with audits performed with respect to the entity for purposes of title XVIII. The Secretary shall specify by regulation such methods as he finds feasible and equitable for the apportionment of the cost of coordinated audits between the program established under title V or XIX and the program established under title XVIII. Where the Secretary finds that a State has declined to participate in such a common audit with respect to title V or XIX, he shall reduce the payments otherwise due such State under such title by an amount which he estimates to be in excess of the amount that would have been apportioned to the State under the title

(for the expenses of the State incurred in the common audit) if it had participated in the common audit.

COORDINATION OF QUALITY ASSURANCE PROGRAMS FOR CLINICAL LABORATORIES

SEC. 1129. (a) For the purpose of promoting the efficient, effective, and consistent application of quality assurance standards for clinical laboratories certified for participation in the programs established by titles V, XVIII, and XIX of this Act and for clinical laboratories subject to the provisions of section 353 of the Public Health Service Act, the Secretary shall, consistent with the authority provided under sections 1861(e) and 1861(s) of this Act for the certification of clinical laboratories and with the authority provided under section 353 of the Public Health Service Act for the licensure of clinical laboratories engaged in interstate commerce, provide for the application of uniform quality assurance standards under such Acts with respect to the classes of clinical laboratories. In promulgating such standards, the Secretary shall include requirements with respect to such personnel in such clinical laboratories as he determines are necessary to assure the consistent performance by clinical laboratories of reliable, accurate laboratory tests and other procedures and services performed by such clinical laboratories.

(b) The Secretary shall take such administrative actions as are necessary to provide for the uniform and consistent application of such quality assurance standards and shall periodically report to the Congress on such actions and their effectiveness in accomplishing the purpose of this section.

PART B—PROFESSIONAL STANDARDS REVIEW

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DESIGNATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1152. (a) * * *

(b) For purposes of subsection (a), the term "qualified organizations" means—

(1) when used in connection with any area—

(A) an organization (i) which is a nonprofit professional association (or a component organization thereof), (ii) which is composed of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area, *and, if the organization so elects, of other health care practitioners engaged in the practice of their profesisons in such area who hold independent hospital admitting privileges*, (iii) the membership of which includes a substantial proportion of all such physicians in such area, (iv) which is organized in a manner which makes available professional competence to review health care services of the types and kinds with respect to which Professional Standards Review Organizations have review responsibilities under this part,

(v) the membership of which is voluntary and open to all doctors of medicine or osteopathy licensed to engage in the practice of medicine or surgery in such area without requirement of membership in or payment of dues to any organized medical society or asosciation, and (vi) which does not (*except as otherwise provided under section 1155(c)*) restrict the eligibility of any member for service as an officer of the profesisonal Standards Review Organization or eligibility for and assignment to duties of such Professional Standards Review Organization, or, subject to subsection (c)(1),

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TRIAL PERIOD FOR PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1154. (a) * * *

(b) During any such trial period (which may not exceed 4 months except as provided in subsection (c) 24 months), the Secretary may require a Professional Standards Review Organization to perform, in addition to review of health care services provided by or in institutions, only such of the duties and functions required under this part of Professional Standards Review Organization as he determines such organization to be capable of performing. The number and type of such duties shall, during the trial period, be progressively increased as the organization becomes capable of added responsibility so that, by the end of such period, such organization shall be considered a qualified organization only if the Secretary finds that it is substantially carrying out in a satisfactory manner, the activities and functions required of Professional Standards Review Organizations under this part with respect to the review of health care services provided by or in [institutions] *hospitals* (including ancillary services) and, in addition, review of such other health care services as the Secretary may require. Any of such duties and functions not performed by such organization during such period shall be performed in the manner and to the extent otherwise provided for under law.

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DUTIES AND FUNCTIONS OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1155. (a)(1) Notwithstanding any other provision of law, but consistent with the provisions of this part, it shall be the duty and function of each Professional Standards Review Organization for any area to assume, [at the earliest date practicable] *to the extent and at the time specified by the Secretary*, responsibility for the review of the professional activities in such area of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services (except as provided in paragraph (7)) and items for which payment may be made (in whole or in part) under this Act for the purpose of determining whether—

(A) such services and items are or were medically necessary;

(B) the quality of such services meets professionally recognized standards of health care; and

(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or more economically in an inpatient health care facility of a different type.

[(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

[(A) any elective admission to a hospital, or other health care facility, or

[(B) any other health care service which will consist of extended or costly courses of treatment,

whether such service, if provided, or if provided by a particular health care practitioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in clauses (A) and (C) of paragraph (1).]

(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

(A) any elective admission to a hospital or other health care facility (including admissions occurring on weekends),

(B) any routine diagnostic services furnished in connection with such an admission, and

(C) any other health care service which will consist of extended or costly courses of treatment,

whether such service, if provided, or if provided by a particular health care practitioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in subparagraphs (A) and (C) of paragraph (1). Each such Organization may be directed by the Secretary to exercise such authority where the Secretary finds that such determinations can be made on a timely basis by the Organization and appropriate procedures will be applied to assure prompt notification of such determinations to providers, physicians, practitioners, and persons on whose behalf payment may be made under this Act for services and items.

* * * * * * *

(8) Each Professional Standards Review Organization shall consult (with such frequency and in such manner as may be prescribed by the Secretary) with representatives of health care practitioners (other than physicians described in section 1861(r)(1)) and of institutional and noninstitutional providers of health care services, in relation to the Professional Standards Review Organization's responsibility for the review under paragraph (1) of the professional activities of such practitioners and providers.

* * * * * *

(g)[(1)] Where a Professional Standards Review Organization (whether designated on a conditional basis or otherwise) requests review responsibilities with respect to services furnished in shared health facilities, the Secretary must give priority to such request, with the highest priority being assigned to requests from organizations located in areas with substantial numbers of shared health facilities.

[(2) The Secretary shall require any Professional Standards Review Organization which is capable of exercising review responsi-

bility with respect to ambulatory care services to perform review responsibility with respect to such services on and after a date not earlier than the date the organization is designated as a Professional Standards Review Organization (other than under section 1154) and not later than two years after the date the organization has been so designated, but any such designated Professional Standards Review Organization may be approved to perform such review responsibility at any earlier time if such organization applies for, and is found capable of exercising, such responsibility.]

(h) If the Secretary has designated an organization (other than under section 1154) as a Professional Standards Review Organization, but that organization has not assumed responsibility for the review of particular activities in its area included in subsection (a)(1), the Secretary may designate another qualified Professional Standards Review Organization (in reasonable proximity to the providers and practitioners whose services are to be reviewed) to assume the responsibility for the review of some or all of those particular activities.

* * * * * *

STATEWIDE PROFESSIONAL STANDARDS REVIEW COUNCILS; ADVISORY GROUPS TO SUCH COUNCILS

SEC. 1162. (a) * * *

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(e)(1) The Statewide Professional Standards Review Council for any State [(or in a State which does not have such Council, the Professional Standards Review Organizations in such State which have agreements with the Secretary)] shall be advised and assisted in carrying out its functions by an advisory group (of not less than seven nor more than eleven members) which shall be made up of representatives (*including at least one registered professional nurse and at least one doctor of dental surgery or of dental medicine*) of health care practitioners (other than physicians) and hospitals and other health care facilities which provide within the State health care services for which payment (in wole or in part) may be made under any program established by or pursuant to this Act.

(2) The Secretary shall by regulations provide the manner in which members of such advisory group shall be selected by the Statewide Professional Standards Review Council [(or Professional Standards Review Organizations in States without such Councils)].

* * * * * * *

NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

SEC. 1163. (a)(1) There shall be established a National Professional Standards Review Council (hereinafter in this section referred to as the "Council") which shall consist of eleven physicians, *one doctor of dental surgery or of dental medicine, one registered professional nurse, one consumer representative, and one other health practitioner (other than a physician as defined in section 1861(r)(1))*, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

(2) Members of the Council shall be appointed for a term of three years, except that the Secretary may provide, in the case of any terms scheduled to expire after January 1, 1978, for such shorter terms as will ensure that (on a continuing basis) the terms of no more than [four] *five* members expire in any year. Members of the Council shall be eligible for reappointment.

(3) The Secretary shall from time to time designate one of the *physician* members of the Council to serve as Chairman thereof.

(b) [Members] *Physician members* of the Council shall consist of physicians of recognized standing and distinction in the appraisal of medical practice. A majority of such members shall be physicians who have been recommended by the Secretary to serve on the Council by national organizations recognized by the Secretary as representing practicing physicians. The membership of the Council shall include physicians who have been recommended for membership on the Council by consumer groups and other health care interests.

* * * * * * *

(f) (1) The Council shall be advised and assisted in carrying out its functions by an advisory committee (of not less than seven nor more than fifteen members) which shall be made up of representatives of health care practitioners (other than physicians described in section 1861(r)(1)) for whose services payment may be made (in whole or in part) under any program established by or pursuant to this Act.

(2) The Secretary shall by regulations provide the manner in which members of such advisory committee shall be selected and the terms of service.

(3) The expenses reasonably and necessarily incurred, as determined by the Secretary, by such committee in carrying out its functions shall be considered to be expenses necessarily incurred by the National Professional Standards Review Council.

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MEDICAL OFFICERS IN AMERICAN SAMOA, THE NORTHERN MARIANA ISLANDS, AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS TO BE INCLUDED IN THE PROFESSIONAL STANDARDS REVIEW PROGRAM

SEC. 1173. For purposes of applying this part (except [sections 1155(c) and 1163)] *section 1155(c))* to American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands, individuals licensed to practice medicine in those places shall be considered to be physicians and doctors of medicine.

VOLUNTARY CERTIFICATION OF SUPPLEMENTARY HEALTH INSURANCE POLICIES

SEC. 1174. (a) The Secretary shall, no later than January 1, 1981, establish a procedure whereby health insurance policies offered by private insurers in supplementation of benefits provided under title XVIII of this Act may be certified by the Secretary as meeting minimum standards with respect to adequacy of coverage, reasonableness of premium charge, and disclosure of information to the insured. Such procedure shall provide an opportunity for any insurer to submit any

such policy to the Secretary for his examination and for his certification thereof as meeting the standards set forth in subsection (b). Such certification shall remain in effect, if the insurer files a notarized statement with the Secretary no later than Deecmber 31 of each year stating the policy continues to meet the standards set forth in subsection (b), and if the insurer submits such additional data as the Secretary finds necessary to independently verify the accuracy of such notarized statement. Where the Secretary determines such a policy meets (or continues to meet) the required standards, he shall authorize the insurer to have printed on such policy an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary's certification. The Secretary shall provide each State insurance commissioner with a list of all the policies which have received his certification.

(b) The Secretary shall not certify under this section any policy unless he finds that such policy—

(1) supplements both part A and part B of title XVIII;

(2) is written in simplified language which can be understood by purchasers;

(3) does not limit or preclude liability under the policy for a period longer than six months because of a health condition existing before the policy is effective;

(4) contains a prominently displayed "no loss cancellation clause" enabling the insured to return the policy within 30 days of the date of sale without financial loss;

(5) can be expected (as estimated in accordance with accepted actuarial principles and practices) to return to policyholders in the form of benefits provided under the policy such percentage of the amount of premiums collected as the Secretary finds reasonable (taking into account all relevant underwriting and other considerations relating to the design and marketing of such policies), except that such percentage may not be less than 75 percent with respect to group policies and 60 percent with respect to individual policies; and

(6) contains a written statement for prospective purchasers of such information as the Secretary shall prescribe relating to (A) the policy's premium, coverage, renewability and coinsurance provisions and (B) the identification of the insurer and its agents.

(c) Any supplementary health insurance policy (as defined in subsection (a)) issued in any State which has established under State law a regulatory program providing for the application of minimum standards with respect to such policies equal to or more stringent than the standards provided for under subsection (b) shall be deemed (for so long as the Secretary finds such State program continues to require compliance with such standards) to meet the standards set forth in subsection (b).

(d) (1) Whoever knowingly or willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the compliance of any policy with the standards set forth in subsection (b) or in regulations promulgated pursuant to such subsection shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years or both.

(2) Whoever falsely assumes or pretends to be acting, or misrepresents in any way that he is acting under the authority of or in association with any program of health insurance established by Federal statute for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years or both.

(e) The Secretary shall make readily available to all persons entitled to benefits under title XVIII (and to the extent feasible, persons about to become so entitled) such information as will permit such persons to evaluate the value of supplementary policies to them and the relationship of any such policies to benefits provided under title XVIII.

(f)(1)(A) The Secretary shall, in consultation with Federal and State regulatory agencies, the National Association of Insurance Commissioners (hereinafter referred to as "NAIC"), private insurers, and organizations representing consumers and the aged, conduct a comprehensive study and evaluation of the comparative effectiveness of various State approaches to the regulation of private supplementary health insurance in: (i) limiting marketing and agent abuse, (ii) assuring the dissemination of such information to individuals entitled to benefits under title XVIII (and to other consumers) as is necessary to permit informed choice, (iii) providing high value policies for such individuals, (iv) reducing the purchase of unnecessary duplicative covverage, and (v) improving price competition.

(B) Such study and evaluation shall include regulatory approaches that provide for the use of: (i) minimum loss ratios; (ii) disclosure of information to prospective purchasers; (iii) minimum benefit level standards; (iv) fixed benefit standards; and (v) the NAIC Model Regulation To Implement the Individual Accident and Sickness Minimum Standards Act.

(C) Such study shall evaluate the extent to which States adopt the amendments regarding medicare supplementary insurance to the NAIC Model Regulation approved by the NAIC on June 6, 1979, how effectively such amendments are implemented, and how successful States which have adopted such amendments have been in achieving the objectives described in subparagraph (A).

(D) The Secretary shall, no later than July 1, 1981, submit a report to the Congress on the results of such study and evaluation (including data relating to the adoption, implementation, and effectiveness of June 6, 1979, amendments to the NAIC Model Regulation regarding medicare supplementary insurance), accompanied by such recommendations as the Secretary finds warranted by such results with respect to the need for legislative or administrative changes to accomplish the objectives set forth in subparagraph (1)(A), including the need for a mandatory Federal regulatory program to assure the marketing of appropriate types of supplementary policies, and such other means as he finds may be appropriate to enhance effective State regulation of such policies.

(2) The Secretary shall submit to the Congress on January 1, 1982 and on each January 1, thereafter, an annual report evaluating the

effectiveness of the certification procedure established under this section, and shall include in such reports an analysis of—

(A) the impact of such procedure on the types, market share, value, and cost to persons entitled to benefits under title XVIII of this Act of supplementary policies which have been certified by the Secretary;

(B) the need for any changes in the certification procedure to improve its administration or effectiveness; and

(C) whether the certification program should be continued.

(g) The Secretary shall prescribe such regulations as may be necessary for the effective, efficient, and equitable administration of the certification procedure established under this section.

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

DESCRIPTION OF PROGRAM

* * * * * * *

PAYMENT TO PROVIDERS OF SERVICES

SEC. 1815. (a) * * *

[(b) No payment shall be made to a provider of services which is a hospital for or with respect to services furnished by it for any period with respect to which it is deemed, under section 1861(w)(2), to have in effect an arrangement with a Professional Standards Review Organization for the conduct of utilization review activities by such organization unless such hospital has paid to such organization the amount due (as determined pursuant to such section) to such organization for the review activities conducted by it pursuant to such arrangements or such hospital has provided assurances satisfactory to the Secretary that such organization will promptly be paid the amount so due to it from the proceeds of the payment claimed by the hospital. Payment under this title for utilization review activities provided by a professional Standards Review Organization pursuant to an arrangement or deemed arrangement with a hospital under section 1861(w)(2) shall be calculated without any requirement that the reasonable cost of such activities be apportioned among the patients of such hospital, if any, to whom such activities were not applicable.]

* * * * * * *

PART C—MISCELLANEOUS PROVISIONS

DEFINITION OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * * * *

Skilled Nursing Facility

(j) The term "skilled nursing facility" means (except for purposes of subsection (a)(2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (1)) with one or more hospitals having agreements in effect under section 1866 and which—

(1) * * *

* * * * * * *

(13) [meets such provisions of the Life Safety Code of the National Fire Protection Association (23d edition, 1973) as are applicable to nursing homes] *meets such provisions of such edition (as is specified by the Secretary in regulations) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes*; except that the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing home, but only if such waiver will not adversely affect the health and safety of the patients; except that the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing facilities;

* * * * * * *

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) * * *

* * * * * * *

(E) rural health clinic services; [and]

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies; *and*

(G) services furnished pursuant to a contract under section 1876 to a member of a health maintenance organization by a physician assistant or by a nurse practitioner and such services and supplies furnished as an incident to his service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service;

* * * * * * *

Reasonable Cost

(v)(1)(A) * * *

* * * * * * *

(G) Where a hospital furnishes inpatient services that would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility on the basis of a determination made by a Professional Standards Review Organization (or, in the absence of such

a qualified organization, by such organization or agency with review responsibility as is otherwise provided for under this title) that (i) post-hospital extended care services are medically necessary; and (ii) that such services are not otherwise available (as determined in accordance with criteria established by the Secretary) at the time the determination is made that post-hospital extended care services rather than inpatient hospital services are medically necessary (and for such period as the circumstances described in clauses (i) and (ii) continue to apply); and where the Secretary finds that (I) such hospital has had, during the immediately preceding calendar year, an average daily occupancy rate of less than 80 percent; and (IV) could be granted a certificate of need for the provision of long-term services from the designated State health planning and development agency for the State in which the hospital is located, the reasonable cost of such services for such hospital shall be computed as provided for in section 1882(a). Where payment is made in accordance with the preceding sentence, the individual who is furnished such services will be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1866.

* * * * * * *

Arrangements for Certain Services

(w)[(1)] The term "arrangements" is limited to arrangements under which receipt of payment by the hospital, a skilled nursing facility, or home health agency (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

[(2) Utilization review activities conducted in, accordance with the requirements of the program established under part B of title XI of the Social Security Act with respect to services furnished by a hospital to patients insured under part A of this title or entitled to have payment made for such services under part B of this title or under a State plan approved under title V or XIX, by a Professional Standards Review Organization designated for the area in which such hospital is located shall be deemed to have been conducted pursuant to arrangements between such hospital and such organization under which such hospital is obligated to pay to such organization, as a condition of receiving payment for hospital services so furnished under this part or under such a State plan, such amount as is reasonably incurred and requested (as determined under regulations of the Secretary) by such organization in conducting such review activities with respect to services furnished by such hospital to such patients.]

* * * * * * *

Rural Health Clinic Services

(aa)(1)***

(2) The term "rural health clinic" means a facility which—

(A) is primarily engaged in furnishing to outpatients services described in subparagraphs (A) and (B) of paragraph (1);

(B) in the case of a facility which is not a physician-directed clinic, has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians (as defined in subsection (r)(1)) under which provision is made for the periodic review by such physicians of covered services furnished by physician assistants and nurse practitioners, the supervision and guidance by such physicians of physician assistants and nurse practitioners, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability of such physicians for such referral of and consultation for patients as is necessary and for advice and assistance in the management of medical emergencies; and, in the case of a physician-directed clinic, has one or more of its staff physicians perform the activities accomplished through such an arrangement;

(C) maintains clinical records on all patients;

(D) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

(E) has written policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more physician assistants or nurse practitioners, to govern those services described in paragraph (1) which it furnishes;

(F) has a physician, physician assistant, or nurse practitioner responsible for the execution of policies described in subparagraph (E) and relating to the provision of the clinic's services;

(G) directly provides routine diagnostic services, including clinical laboratory services, as prescribed in regulations by the Secretary, and has prompt access to additional diagnostic services from facilities meeting requirements under this title;

(H) in compliance with State and Federal law, has available for administering to patients of the clinic at least such drugs and biologicals as are determined by the Secretary to be necessary for the treatment of emergency cases (as defined in regulations) and has appropriate procedures or arrangements for storing, administering, and dispensing any drugs and biologicals;

(I) has appropriate procedures for review of utilization of clinic services to the extent that the Secretary determines to be necessary and feasible; and

(J) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For the purposes of this title, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) and that is designated by the Secretary either (I) as an area with a shortage of personal health services under section 1302(7) of the Public Health Service Act or (II) as a health manpower shortage area described in section 332(a)(1)(A) of that

Act because of its shortage of primary medical care manpower, (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1833, (iii) employs a physician assistant or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this title or title XIX and that subsequently fails to satisfy the requirement of clause (i) shall be considered, for purpose of this title and title XIX, as still satisfying the requirement of such clause.

Physician Assistant and Nurse Practitioner

[(3)] (*bb*) The term "physician assistant" and the term "nurse practitioner" mean[, for the purposes of paragraphs (1) and (2),] a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

* * * * * * *

EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) * * *

* * * * * * *

[(e) (1) Whenever the Secretary determines that a physician or other individual practitioner has been convicted (on or after the date of the enactment of this subsection, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such physician's or practitioner's involvement in the programs under this title or the program under title XIX, the Secretary shall suspend such physician or practitioner from participation in the program under this title for such period as he may deem appropriate; and no payment may be made under this title with respect to any item or service furnished by such physician or practitioner during the period of such suspension. The provisions of paragraphs (2) and (3) of subsection (d) shall apply with respect to determinations made by the Secretary under this subsection.

[(2) In any case where the Secretary under paragraph (1) suspends any physician or other individual practitioner from participation in the program under this title, he shall—

[(A) promptly notify each single State agency which administers or supervises the administration of a State plan approved under title XIX of the fact, circumstances, and period of such suspension; and

[(B) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such physician or practitioner of the fact and circumstances of such suspension, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health, Education, and Welfare fully and currently informed with respect to any actions taken in response to such request.]

(e) *No payment may be made under this title with respect to any item or service furnished by a physician or other individual during the period when he is barred pursuant to section 1127 from participation in the program under this title.*

* * * * * * *

USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

SEC. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether a facility therein is a rural health clinic as defined in section 1861(aa)(2), or whether a laboratory meets the requirements of paragraphs (10) and (11) of section 1861(s), or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1861 (p)(4). To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, or home health agency (as those terms are defined in section 1861) may be treated as such by the Secretary. [Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1861(j). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement.] Within 90 days following the completion of each survey of any health care facility, rural health clinic, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, rural health clinic, laboratory, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such health care facility, rural health clinic, laboratory, clinic, agency, or organization.

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)), and

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title, and

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person, and

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this title) with respect to the provider.

[An agreement under this paragraph with a skilled nursing facility shall be for a term of not exceeding 12 months, except that the Secretary may extend such term for a period not exceeding 2 months, where the health and safety of patients will not be jeopardized thereby, if he finds that such extension is necessary to prevent irreparable harm to such facility or hardship to the individuals being furnished items or services by such facility or if he finds it impracticable within such 12-month period to determine whether such facility is complying with the provisions of this title and regulations thereunder.]

* * * * * * *

(b) An agreement with the Secretary under this section may be terminated [(and in the case of a skilled nursing facility, prior to the end of the term specified in subsection (a)(1)]—

(1) * * *

* * * * * * *

(f)(1) Where the Secretary determines that a skilled nursing facility which has filed an agreement pursuant to subsection (a)(1) no longer substantially meets the provisions of section 1861(j), but fur-

ther determines that the facility's deficiencies do not immediately jeopardize the health and safety of its patients, the Secretary may, in lieu of terminating the agreement with such facility, provide that no payment shall be made under this title (and order a State agency established or designated pursuant to section 1902(a)(5) of this Act to administer or supervise the administration of the State plan under title XIX of this Act to deny payment under title XIX) with respect to any individual admitted to such facility after a date specified by him.

(2) The Secretary shall not make such a decision with respect to a facility until such facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The Secretary's decision to deny payment may be made effective only after such notice to the public and to the facility as may be prescribed in regulations, and its effectiveness shall terminate (A) when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j) or (B) with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If the facility still fails to substantially meet the provisions of section 1861(j) on the date specified in clause (B) of the previous sentence, the Secretary shall terminate such facility's agreement, notwithstanding the provisions of paragraph (2) of subsection (b), effective with the first day of the first month following the month specified in such clause.

* * * * * * *

[PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

[SEC. 1876. (a)(1) In lieu of amounts which would otherwise be payable pursuant to sections 1814(b) and 1833(a), the Secretary is authorized to determine, by actuarial methods, as provided in this section, but only with respect to a health maintenance organization with which he has entered into a contract under subsection (i), a per capita rate of payment—

[(A) for services provided under parts A and B for individuals enrolled with such organization pursuant to subsection (e) who are entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B, and

[(B) for services provided under part B for individuals enrolled with such organization pursuant to subsection (e) who are not entitled to benefits under part A but who are enrolled for benefits under Part B.

[(2) An interim per capita rate of payment for each health maintenance organization shall be determined annually by the Secretary on the basis of each organization's annual operating budget and enrollment forecast which shall be submitted (in such form and in such detail as the Secretary may prescribe) at least 90 days before the beginning of each contract year. Each interim rate shall be equal to the estimated per capita cost (based upon types and components of expenses otherwise reimbursable under this title) of providing services

defined in paragraph (3) (A) (iii). In the event that the data requested to be furnished by a health maintenance organization are not furnished timely, such reduction in interim payments may be made by the Secretary as is appropriate, until such time as a reasonable estimate of per capita costs can be made. Each month, the Secretary shall pay each such organization its interim per capita rate, in advance, for each individual enrolled with it pursuant to subsection (e). Each such organization shall submit interim estimated cost reports and enrollment data on a quarterly basis in such form and manner satisfactory to the Secretary, and the Secretary shall adjust each interim per capita rate to the extent necessary to maintain interim payments at the level of current costs. Interim payments made under this paragraph shall be subject to retroactive adjustment at the end of each contract year as provided in paragraph (3).

[(3) (A) With respect to any health maintenance organization which has entered into a risk sharing contract with the Secretary pursuant to subsection (i) (2) (A, payments made to such organization shall be subject to the following adjustments at the end of each contract year:

[(i) if the Secretary determines that the per capita incurred cost of any such organization in any contract year for providing services described in paragraph (1) is less than the adjusted average per capita incurred cost (as defined herein) of providing such services, the resulting difference (hereinafter referred to as "savings") shall be apportioned following the close of a contract year for such year between such organization and the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (hereinafter collectively referred to as the "Medicare Trust Funds") as follows:

[(I) savings up to 20 percent of the adjusted average per capita cost shall be apportioned equally between such organization and the Medicare Trust Funds;

[(II) savings in excess of 20 percent of the adjusted average per capita cost shall be apportioned entirely to such Trust Funds;

[(ii) if the Secretary determines that the per capita incurred cost of any such organization in any contract year for providing services described in paragraph (1) is greater than the adjusted average per capita incurred cost of providing such services, the resulting differences (hereinafter referred to as "losses"), shall be absorbed by such organization, and shall be carried forward and offset from savings realized in later years;

[(iii) determination of any amounts payable at the close of the contract year to such organization or to the Trust Funds shall be made as follows:

[(I) within in 90 days after close of a contract year, interim determination of the amount of estimated savings and apportionment thereof shall be made, actuarially, on the basis of interim reports of costs incurred by an organization, and adjusted average per capita costs incurred (as defined herein), and other evidence acceptable to the Secretary and one-half of any amounts deemed payable to such organization or the

Trust Funds shall be paid by such organization or the Secretary as appropriate;

[(II) final settlement and payment by the Secretary or organization, as appropriate, of any additional amounts due on basis of such final settlement will be made where adequate data for actuarial computation are available, in timely fashion following submission by such organization of reports specified in subparagraph (C) of this paragraph; and

[(III) where such final settlement is reached more than 90 days following submission of reports specified in subparagraph (C) of this paragraph, any amount payable by the Secretary or organization shall be increased by an interest amount, accruing from the 91st day following submission of such report, equal to the average rate of interest payable on Federal obligations if issued on such 91st day for purchase by the Trust Funds.

[(iv) The term "adjusted average per capita cost" means the average per capita amount that the Secretary determines (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in the geographic area served by a health maintennce organization or in a similar area, with appropriate adjustment to assure actuarial equivalence, including adjustments relating to age distribution, sex, race, institutional status, disability status, and any other relevant factors) would be payable in any contract year for services covered under this title and types of expenses otherwise reimbursable under this title (including administrative costs incurred by organizations described in sections 1816 and 1842) if such services were to be furnished by other than such health maintenance organization.

[(B) With respect to any health maintenance organization which has entered into a reasonable cost reimbursement contract with the Secretary pursuant to subsection (i)(2)(B) payments made to such organization shall be subject to suitable retroactive corrective adjustments at the end of each contract year so as to assure that such organization is paid for the reasonable cost actually incurred (excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of health services) for the types of expenses otherwise reimbursable under this title for providing services covered under this title to individuals described in paragraph (1).

[(C) Any contract with a health maintenance organization under this title shall provide that the Secretary shall require, at such time following the expiration of each accounting period of a health maintenance organization (and in such form and in such detail) as he may prescribe:

[(i) that such health maintenance organization report to him in an independently certified financial statement its per capita incurred cost based on the types and components of expenses otherwise reimbursable under this title for providing services described in paragraph (1), including therein, in accordance with accounting procedures prescribed by the Secretary, its methods

of allocating costs between individuals enrolled under this section and other individuals enrolled with such organizations;

[(ii) that failure to report such information as may be required may be deemed to constitute evidence of likely overpayment on the basis of which appropriate collection action may be taken;

[(iii) that in any case in which a health maintenance organization is related to another organization by common ownership or control, a consolidated financial statement shall be filed and that the allowable costs for such organization may not include costs for the types of expense otherwise reimbursable under this title, in excess of those which would be determined to be reasonable in accordance with regulations (providing for limiting reimbursement to costs rather than charges to the health maintenance organization by related organizations and owners) issued by the Secretary in accordance with section 1861(v) of the Social Secretary Act; and

[(iv) that in any case in which compensation is paid by a health maintenance organization substantially in excess of what is normally paid for similar services by similar practitioners (regardless of method of compensation), such compensation may as appropriate be considered to constitute a distribution of profits.

[(4) The payment to health maintenance organizations under this subparagraph with respect to individuals described in subsection (a)(1)(A) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of such payment to such an organization for a month to be paid by the latter trust fund shall be equal to 200 percent of the sum of—

[(A) the product of (i) the number of covered enrollees of such organization for such month (as described in paragraph (1)) who have attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for such month as determined under section 1839(c)(1), and

[(B) the product of (i) the number of covered enrollees of such organization for such month (as described in paragraph (1)) who have not attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for such month as determined under section 1839(c)(4).

The remainder of such payment shall be paid by the former trust fund. For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

[(b)(1) The term "health maintenance organization" means a legal entity which provides health services on a prepayment basis to individuals enrolled with such organizations and which—

[(A) provides to its enrollees who are insured for benefits under parts A and B of this title or for benefits under part B alone, through institutions, entities, and persons meeting the applicable requirements of section 1861, all of the services and benefits covered under such parts (to the extent applicable under subparagraph (A) or (B) of subsection (a)(1)) which are available to

individuals residing in the geographic area served by the organization;

[(B) provides such services in the manner prescribed by section 1301(b) of the Public Health Service Act, except that solely for the purposes of this section—

[(i) the term "basic health services" and references thereto shall be deemed to refer to the services and benefits included under parts A and B of this title;

[(ii) the organization shall not be required to fix the basic health services payment under a community rating system;

[(iii) the additional nominal payments authorized by section 1301(b)(1)(D) of such Act shall not exceed the limits applicable under subsection (g) of this section; and

[(iv) payment for basic health services provided by the organization to its enrollees under this section or for services such enrollees receive other than through the organization shall be made as provided for by this title;

[(C) is organized and operated in the manner prescribed by section 1301(c) of the Public Health Service Act, except that solely for the purposes of this section—

[(i) the term "basic health services" and references thereto shall be deemed to refer to the services and benefits included under parts A and B of this title;

[(ii) the organization shall not be reimbursed for the cost of reinsurance except as permitted by subsection (i) of this section; and

[(iii) the organization shall have an open enrollment period as provided for in subsection (k) of this section.

[(2)(A) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a "health maintenance organization" within the meaning of paragraph (1), shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

[(B) Except as provided in subparagraph (A), the Secretary shall administer the provisions of this section through the Administrator of the Health Care Financing Administration.

[(c) The benefits provided under this section to enrollees of an organization which has entered into a risk sharing contract with the Secretary pursuant to subsection (i)(2)(A) shall consist of—

[(1) in the case of an individual who is entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B—

[(A) entitlement to have payment made on his behalf for all services described in section 1812 and section 1832 which are furnished to him by the health maintenance organization with which he is enrolled pursuant to subsection (e) of this section; and

[(B) entitlement to have payment made by such health maintenance organization to him or on his behalf for (i) such emergency services (as defined in regulations), (ii) such

urgently needed services (as defined in regulations) furnished to him during a period of temporary absence (as defined in regulations) from the geographic area served by the health maintenance organization with which he is enrolled, and (iii) such other services as may be determined, in accordance with subsection (f), to be services which the individual was entitled to have furnished by the health maintenance organization, as may be furnished to him by a physician, supplier, or provider of services, other than the health maintenance organization with which he is enrolled; and

[(2) in the case of an individual who is not entitled to hospital insurance benefits under part A but who is enrolled for medical insurance benefits under part B, entitlement to have payment made for services described in paragraph (1), but only to the extent that such services are also described in section 1832.

[(d) Subject to the provisions of subsection (e), every individual described in subsection (c) shall be eligible to enroll with any health maintenance organization (as defined in subsection (b)) which serves the geographic area in which such individual resides.

[(e) An individual may enroll with a health maintenance organization under this section, and may terminate such enrollment, as may be prescribed by regulations.

[(f) Any individual enrolled with a health maintenance organization under this section who is dissatisfied by reason of his failure to receive without additional cost to him any health service to which he believes he is entitled shall, if the amount in controversy is $100 or more, be entitled to a hearing before the Secretary to the same extent as is provided in section 205(b) and in any such hearing the Secretary shall make such health maintenance organization a party thereto. If the amount in controversy is $1,000 or more, such individual or health maintenance organization shall be entitled to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

[(g)(1) If the health maintenance organization provides its enrollees under this section only the services described in subsection (c), its premium rate or other charges for such enrollees shall not exceed the actuarial value of the deductible and coinsurance which would otherwise be applicable to such enrollees under part A and part B, if they were not enrolled under this section.

[(2) If the health maintenance organization provides to its enrollees under this section services in addition to those described in subsection (c), election of coverage for such additional services shall be optional for such enrollees and such organization shall furnish such enrollees with information on the portion of its premium rate or other charges applicable to such additional services. The portion of its premium rate or other charges applicable to the services described in subsection (c) shall not exceed the actuarial value of the deductible and coinsurance which would otherwise be applicable to such enrollees under part A and part B if they were not enrolled under this section.

[(h)(1) Except as provided in paragraph (2), each health maintenance organization with which the Secretary enters into a contract

under this section shall have an enrolled membership at least half of which consists of individuals who have not attained age 65.

[(2) The Secretary may waive the requirement imposed in paragraph (1) for a period of not more than three years from the date a health maintenance organization first enters into an agreement with the Secretary pursuant to subsection (i), but only for so long as such organization demonstrates to the satisfaction of the Secretary by the submission of its plan for each year it is making continuous efforts and progress toward compliance with the provisions of paragraph (1) within such three-year period.

[(i)(1) Subject to the limitations contained in subparagraphs (A) and (B) of paragraph (2), the Secretary is authorized to enter into a contract with any health maintenance organization which undertakes to provide, on an interim per capita prepayment basis, the services described in section 1832 (and section 1812, in the case of individuals who are entitled to hospital insurance benefits under part A) to individuals enrolled with such organization pursuant to subsection (e).

[(2)(A) If the health maintenance organization (i) has a current enrollment of not less than 25,000 members on a prepaid capitation basis and has been the primary source of health care of at least 8,000 persons in each of the two years immediately preceding the contract year, or (ii) serves a nonurban geographic area, has a current enrollment of not less than 5,000 members on a prepaid capitation basis and has been the primary source of health care for at least 1,500 persons in each of the three years immediately preceding the contract year, the Secretary may enter into a risk sharing contract with such organization pursuant to which any savings, as determined pursuant to subsection (a)(3)(A), are shared between such organization and the Medicare Trust Funds in the manner prescribed in such subsection. For purposes of this subparagraph, a health maintenance organization shall be considered to serve a nonurban geographic area if it is located in a nonmetropolitan county (that is, a county with fewer than 50,000 inhabitants), or if it has at least one such county in its normal service area, or if it is located outside of a metropolitan area and its facilities are within reasonable travel distance (as defined by the Secretary) of fewer than 50,000 individuals. No health maintenance organization which has entered into a risk-sharing contract with the Secretary under this subparagraph and has voluntarily terminated such contract may again enter into such a contract.

[(B) If the health maintenance organization does not meet the requirements of subparagraph (A), or if the Secretary is not satisfied that the health maintenance organization has the capacity to bear the risk of potential losses as determined under clause (ii) of subsection (a)(3)(A), or if the health maintenance organization meeting the requirements of subparagraph (A) so elects, or if an organization does not fully meet the requirements of section 1876(b) but has demonstrated to the satisfaction of the Secretary that it is making reasonable efforts to meet, and is developing the capability to fully meet, such requirements, and that it fully meets such basic requirements as the Secretary shall prescribe in regulations, the Secretary may, if he is otherwise satisfied that the health maintenance organization or other

organization is able to perform its contractual obligations effectively and efficiently, enter into a contract with such organization pursuant to which such organization is reimbursed on the basis of its reasonable cost (as defined in section 1861 (v)) in the manner prescribed in subsection (a)(3)(B).

[(3) Such contract may, at the option of such organization, provide that the Secretary (A) will reimburse hospitals and skilled nursing facilities for the reasonable cost (as determined under section 1861(v) of services furnished to individuals enrolled with such organization pursuant to subsection (e), and (B) will deduct the amount of such reimbursement from payments which would otherwise be made to such organization. If a health maintenance organization pays a hospital or skilled nursing facility directly, the amount paid shall not exceed the reasonable cost of the services (as determined under section 1861(v)) unless such organization demonstrates to the satisfaction of the Secretary that such excess payments are justified on the basis of advantages gained by the organization.

[(4) Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the health maintenance organization involved as he may provide in regulations), if he finds that the organization (A) has failed substantially to carry out the contract, (B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or (C) no longer substantially meets the applicable conditions of subsection (b).

[(5) The effective date of any contract executed pursuant to this subsection shall be specified in such contract pursuant to the regulations.

[(6) Each contract under this section—

(A) shall provide that the Secretary, or any person or organization designated by him—

[(i) shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under such contract; and

[(ii) shall have the right to audit and inspect any books and records of such health maintenance organization which pertain to services performed and determinations of amounts payable under such contract;

[(B) shall provide that no reinsurance costs (other than costs with respect to out-of-area services and, in the case of an organization which has entered into a risk-sharing contract with the Secretary pursuant to paragraph (2)(A), the cost of providing any member with basic health services the aggregate value of which exceeds $5,000 in any year), including any underwriting of risk relating to costs in excess of adjusted average per capita cost, as defined in clause (iii) of subsection (a)(3)(A), shall be allowed for purposes of determining payments authorized under this section; and

[(C) shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary.

[(j) The function vested in the Secretary by subsection (i) may be performed without regard to such provisions of law or of other regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.]

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

SEC. 1876. (a) (1) The Secretary shall annually determine a per capita rate of payment—

(A) for each class of individuals who are enrolled (in accordance with this section) with a health maintenance organization which has entered into a contract under this section and who are entitled to benefits under part A and enrolled under part B; and

(B) for each class of individuals who are so enrolled with such an organization and who are enrolled under part B only.

Such rate for each class shall be equal to 95 percent of the adjusted average per capita cost for that class.

(2) For purposes of this section, the term "adjusted average per capita cost" means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by health maintenance organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for services covered under parts A and B, or part B only, and types of expenses otherwise reimbursable under parts A and B, or part B only (including administrative costs incurred by organizations described in sections 1816 and 1842), if the services were to be furnished by other than a health maintenance organization or, in the case of services covered only under section 1861(s)(2)(G), if the services were to be furnished by a physician or as an incident to a physician's service.

(3) In establishing classes of individuals for purposes of this subsection, the Secretary shall take into consideration such factors as age, sex, institutional status, disability status, and place of residence.

(4) After determining under paragraph (1) the rate of payment to be utilized with respect to a health maintenance organization, the Secretary shall make monthly payments, in advance and in accordance with such rate, except as provided in subsection (i)(2), to such organization for each individual enrolled in accordance with this section with the organization. Such payments shall be in lieu of payments which (in the absence of the contract entered into under this section) would be payable otherwise pursuant to section 1814(b) or 1833(a) for services furnished by or through the organization to individuals enrolled with the organization and entitled to benefits under part A and enrolled under part B or enrolled under part B only.

(5) The payment to a health maintenance organization under this subsection for individuals enrolled in accordance with this section with

this section with the organization and entitled to benefits under part A and enrolled under part B shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of that payment to the organization for a month to be paid by the latter trust fund shall be equal to 200 percent of the sum of—

"(A) the product of (i) the number of such individuals for the month who have attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1839(c)(1); and

"(B) the product of (i) the number of such individuals for the month who have not attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1839(c)(4).

The remainder of that payment shall be paid by the former trust fund

(b)(1) For purposes of this section, the term "health maintenance organization" means a legal entity which provides services in the manner prescribed by section 1301(b) of the Public Health Service Act and is so organized and operated in the manner prescribed by section 1301(c) of the Public Health Service Act, except that—

(A) solely for the purposes of this section—

(i) the term "basic health services" and references thereto shall be deemed to refer to the services and benefits included in parts A and B of this title;

(ii) the additional nominal payments authorized by section 1301(b)(1)(D) of the Public Health Service Act shall not exceed the limits applicable under subsection (g) of this section; and

(iii) the organization provides the services covered under meeting the applicable requirements of section 1861; and

(B) with respect to the enrollment of individuals with the organization under this section—

(i) subsections (c)(4) and (d) of section 1301 of the Public Health Service Act shall not apply, and

(ii) the organization shall have an open enrollment period of reasonable duration at least every year during which it accepts up to the limits of its capacity and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment, unless to do so would result in failure to meet the requirements of subsection (h) or would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by such organization.

(2)(A) The administration of the duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a health maintenance organization within the meaning of paragraph (1), shall be integrated with the administration of title XIII of the Public Health Service Act.

(B) Except as provided in subparagraph (A), the Secretary shall administer the provisions of this section through the Administrator of the Health Care Financing Administration.

(c) If an individual is enrolled in accordance with this section with a health maintenance organization, only the health maintenance organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

(d) Subject to the provisions of subsection (e), every individual entitled to benefits under part A and enrolled under part B or enrolled under part B only (other than an individual medically determined to have end-stage renal disease) shall be eligible to enroll under this section with any health maintenance organization with which the Secretary has entered into a contract under this section and which serves the geographic area in which the individual resides.

(e)(1) An individual may enroll under this section with a health maintenance organization as may be prescribed in regulations and may terminate his enrollment with the health maintenance organization as of the beginning of the first calendar month following a full calendar month after the request is made for such termination.

(2) The Secretary may prescribe the procedures and conditions under which a health maintenance organization that has entered into a contract with the Secretary under this subsection may inform individuals eligible to enroll under this section with the organization about the organization, or may enroll such individuals with the organization.

(f) Any individual enrolled with a health maintenance organization under this section who is dissatisfied by reason of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay shall, if the amount in controversy is $100 or more, be entitled to a hearing before the Secretary of the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the health maintenance organization a party. If the amount in controversy is $1,000 or more, the individual or health maintenance organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the health maintenance organization shall be entitled to be parties to that judicial review.

(g)(1) In no case may—

(A) the portion of a health maintenance organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under parts A and B) to individuals who are enrolled in accordance with this section with the organization and who are entitled to benefits under part A and enrolled under part B, or

(B) the portion of its premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under part B) to individuals who are enrolled in accordance with this section with the organization and enrolled under part B only

exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled in accord-

ance with this section with the organization (or, if the Secretary finds that adequate data are not available to determine that actuarial value, other appropriate data) and entitled to benefits under part A and enrolled under part B, or enrolled under part B only, respectively, if they were not members of a health maintenance organization.

(2) If the health maintenance organization provides to its enrollees under this section services in addition to services covered under parts A and B of this title, election of coverage for such additional services shall be optional for such enrollees and such organization shall furnish such enrollees with information of a portion of its premium rate or other charges applicable to such additional services. In no case may—

(A) the portion of such organization's premium rate charged, with respect to such additional services, to individuals enrolled in accordance with this section, and

(B) the actuarial value of its deductibles, coinsurance, and copayments charged, with respect to such services, to such individuals

exceed the adjusted community rate for such services.

(3) For purposes of this section, the term "adjusted community rate" for a service means the rate of payment for that service which the Secretary annually estimates would apply to an individual enrolled in accordance with this section with a health maintenance organization if the rate of payment were determined under a "community rating system" (a defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), but adjusted for differences between the utilization characteristics of the individuals enrolled with the health maintenance organization under this section and utilization characteristics of the other members of the organization (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals in other health maintenance organizations, or individuals in the area, in the State, or in the United States, eligible to enroll under this section with a health maintenance organization and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

(4) Notwithstanding any other provision of law, the health maintenance organization may (in the case of the provision of services to an individual enrolled in accordance with this section for an illness or injury for which the member is entitled to benefits under a workman's compensation law or under an automobile insurance policy) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

(A) the insurance carrier, employer, or other entity which under such law or policy is to pay for the provision of such services, or

(B) such member to the extent that such member has been paid under such law or policy for such services.

(h)(1) Except as provided in paragraph (2), each health maintenance organization with which the Secretary enters into a contract under this section shall have, for the duration of such contract, an enrolled membership at least half of which consists of individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.

(2) the Secretary may modify or waive the requirement described in paragraph (1) in circumstances which, as determined by the Secretary, warrant special consideration (and may take into account, in determining whether to modify or waive that requirement, the reasonableness of the organization's premium rate and other charges for members entitled to benefits under this title or under a State plan approved under title XIX); except that the Secretary may make such a modification or waiver only on the condition that the health maintenance organization will not have, for the duration of such contract, an enrolled membership of which one-half or more are individuals entitled to benefits under part A or enrolled under part B.

(i)(1) The Secretary may enter into a contract with any health maintenance organization, as defined in subsection (b)(1), for the purpose of carrying out this section.

(2) Each contract shall provide that—

(A) if the adjusted community rate, as defined in subsection (g)(3), for services covered under parts A and B (as reduced for the actuarial value of the coinsurance and deductibles under those parts) for individuals enrolled in accordance with this section with the organization and entitled to benefits under part A and enrolled in part B, or

(B) if such adjusted community rate for services under part B (as reduced for the actuarial value of the coinsurance and deductibles under that part) for individuals enrolled in accordance with this section with the organization and enrolled under part B only

is less than the average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of an annual contract period for individuals enrolled in accordance with this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the health maintenance organization shall provide to each individual enrolled in accordance with this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B, respectively, additional benefits which are selected by the health maintenance organization and which the Secretary finds are at least equal in value to the difference between the average per capita payment and the adjusted community rate (as so reduced); except that this paragraph shall not apply with respect to any organization which elects to receive a lesser payment to the extent that there is no longer a difference between the average per capita payment and adjusted community rate (as so reduced). If the Secretary finds that there is insufficient enrollment experience to determine an average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this section.

(3) Such additional benefits shall be (A) the reduction of the premium rate or other charges made with respect to services furnished by the organization to individuals enrolled under this section, or (B) the provision of additional benefits described as basic or supplemental health services in section 1302 of the Public Health Service, or both.

(4) Each contract under this section shall be for a term of at least

one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the health maintenance organization involved as he may provide in regulations), if he finds the organization (A) has failed substantially to carry out the contract, (B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or (C) no longer substantially meets the applicable conditions of subsection (b).

(5) The effective date of any contract executed pursuant to this subsection shall be specified in the contract.

(6) Each contract under this section—

(A) shall provide that the Secretary, or any person or organization designed by him—

(i) shall have right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the contract, and

(ii) shall have right to audit and inspect any books and records of the health maintenance organization that pertain (I) to the capacity of the organization to bear the risk of potential financial losses, and (II) to services performed or determinations of amounts payable under the contract,

(B) shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled under this section with the organization,

(C) shall require the organization to comply with subsections (a) and (c) of section 1318 of the Public Health Service Act, and

(D) shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary.

(7) The Secretary may not enter into contract with a health maintenance organization under this section if a former contract with that organization under this section was terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

(8) The authority vested in the Secretary by this subsection may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

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HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES

SEC. 1882. (a)(1) Any hospital (other than a hospital which has in effect a waiver of the requirement imposed by section 1861(e)(5)) which has an agreement under section 1866 may (subject to subsection (b)) enter into an agreement with the Secretary under which its in-

patient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute post-hospital extended care services.

(2)(A) Notwithstanding any other provision of this title, payment to any hospital for services furnished under an agreement entered into under this section shall be based upon the reasonable cost of the services as determined under subparagraph (B).

(B)(i) The reasonable cost of the services consists of the reasonable cost of routine services (determined under clause (ii)) and the reasonable cost of ancillary services (determined under clause (iii)).

(ii) The reasonable cost of routine services furnished during any calendar year by a hospital under an agreement under this section is equal to the product of (I) the number of patients days during the year for which the services were furnished, and (II) the average reasonable cost per patient-day, such average reasonable cost per patient-day being the average rate per patient-day paid for routine services during the previous calendar year under title XIX to skilled nursing facilities located in the State in which the hospital is located and which have agreements entered into under section 1902(a)(28).

(iii) The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(b) The Secretary may not enter into an agreement under this section with any hospital unless the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 1521 of the Public Health Service Act) for the State in which the hospital is located.

(c) An agreement with a hospital under this section shall, except as otherwise provided under regulations of the Secretary, be subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1866 (unless the hospital fails to satisfy the requirements specified in subsection(b)) and shall, where not inconsistent with any provision of this section, impose the same duties, responsibilities, conditions and limitations, as those imposed under such agreements entered into under section 1866; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1866, or where there is in effect for the hospital a waiver of the requirement imposed by section 1861(e)(5). A hospital whose agreement under this section has been terminated shall not be eligible to undertake a new agreement until a two-year period has elapsed from the termination date.

(d) Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as post-hospital extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this title (other than this section), be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services fur-

nished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1866.

(e) During a period for which a hospital has in effect an agreement under this section, in order to allocate routine costs between hospital and long-term care services for purposes of determining payment for inpatient hospital services, the total reimbursement received for routine services from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital's total routine costs before calculations are made to determine title XVIII reimbursement for routine hospital services.

(f) A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1861(j)(15). Services furnished by such a hospital which would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.

(g) The Secretary shall prescribe by regulation an alternative method for determining the amount of the reasonable cost of post-hospital extended care services furnished in a distinct part of a hospital certified as a skilled nursing facility under section 1861(j) that is the same method as the method prescribed in subsections (a) and (e) for determining the amount of the reasonable cost for such services furnished by a hospital that uses beds interchangeably for either acute or long-term care and shall approve the use of this method when a hospital can demonstrate that its use would contribute significantly to the more efficient or effective administration of this part and would be in the interest of program beneficiaries.

TITLE XIX GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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State Plans for Medical Assistance

Sec. 1902. (a) A State plan for medical assistance must—

* * * * * * *

(13) provide—

(A) (i) for the inclusion of some institutional and some noninstitutional care and services, and

(ii) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services, and

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or Part A of title XIV, or with respect to whom supplemental security income benefits are being paid under title

XVI, for the inclusion of at least the care and services listed in clauses (1) through (5) of section 1905(a), and

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in clauses (1) through (5) of section 1905(a) or

(i)(I) the care and services listed in any 7 of the clauses numbered (i) through (16) of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hospital services from such hospital or skilled nursing facility services from such facility, and

(D) for payment (*except where the State agency is subject to an order under section 1913*) of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1122, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII; and

(E) effective July 1, 1976, for payment (*except where the State agency is subject to an order under section 1913*) of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary; and

[(35) provide that any intermediate care facility receiving payments under such plan complies with the requirements of section 1124;]

(*35*) *provide that any entity (as defined in section 1124(a)(2)) receiving payments under such plan complies with the requirements of section 1124;*

* * * * * * *

[(39) provide that, subject to subsection (g), whenever the single State agency which administers or supervises the administration of the State plan is notified by the Secretary under section 1862(e)(2)(A) that a physician or other individual practitioner has been suspended from participation in the program under title XVIII, the agency shall promptly suspend such physician or practitioner from participation in the plan for not less than the period specified in such notice, and no payment may be made under the plan with respect to any item or service furnished by such physician or practitioner during the period of the suspension under this title;]

(*39*) *provide that the State agency shall bar any specified individual from participation in the program under the State plan for*

the period specified by the Secretary, when required by him to do so pursuant to section 1127, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual during such period;

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1121(a) to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization[.]*; and*

(41) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under part A of title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of the proportion of costs of each such common audit of such an entity equal to the proportion of total program benefit payments to the entity (by all third-party payers participating in the common audit for the period being audited) which are payments under this title.

* * * * * * *

[(g) The Secretary may waive suspension under subsection (a)(39) of a physician's or practitioner's participation in a State plan approved under this title and of the prohibition under such subsection of payment for any item or service furnished by him during the period of such suspension, if the single State agency which administers or supervises the administration of the plan submits a request to the Secretary for such waiver and if the Secretary approves such request.]

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PAYMENT TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections [(g) and (h)] *(g), (h), and (j)* of this section) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of title XVIII, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount,

duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under title XVIII or who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof); plus

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[(j)(1) Notwithstanding the preceding provisions of this section, no payment shall be made to a State (except as provided under this subsection) with respect to expenditures incurred by it for services provided by any institution during any period that an order for suspension of payment (as authorized by this subsection) is effective with respect to such institution.

[(2) The Secretary may issue a suspension of payment order with respect to any institution if—

[(A) such institution (i) does not (at the time such order is issued) have in effect an agreement with the Secretary which is entered into pursuant to section 1866; and (ii) did (prior to the time such order is issued) have in effect such an agreement; and

[(B)(i) The Secretary has been unable to collect (or make satisfactory arrangement for the collection of) amounts due on account of overpayments made to such institution under title XVIII; or

[(ii) the Secretary has been unable to obtain from such institution the data and information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under title XVIII.

[(3) Whenever the Secretary issues any order for suspension of payment under this subsection with respect to any institution, he shall submit a notice of such order to the single State agency (referred to in section 1902(a)(5)) of each State which he has reason to believe does or may utilize the services of such institution in providing medical assistance under a plan approved under this title.

[(4) Any order for suspension of payment issued with respect to any institution under this subsection shall become effective, in the case of any State plan approved under this title, on the 60th day after the date the State agency (referred to in section 1902(a)(5)) administering or supervising the administration of such plan receives notice of such order submitted pursuant to paragraph (3). Any such order shall cease to be effective at such time as the Secretary is satisfied that the institution is participating in substantial negotiations which seek to remedy the conditions which gave rise to his order of suspension of payments, or that the amounts (referred to in paragraph (2)) are no longer due from such institution or that a satisfactory arrangement has been made for the payment by such institution of any such amounts. Upon the determination of the Secretary that any such order with respect to any such institution shall cease to be effective, he shall forthwith notify each State agency to which he has theretofore submitted notice under paragraph (3) with respect to such institution.

[(5) Whenever any order which has been issued by the Secretary under the preceding provisions of this subsection with respect to an

institution ceases to be effective, any payment to which any State would (except for the preceding provisions of this subsection) have been entitled under this section on account of services provided by such institution shall be made to such State for the month in which such order ceases to be effective.]

(j) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter shall be adjusted in accordance with section 1913.

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(r)(1) Notwithstanding the preceding provisions of this section, no payment shall be made to a State (except as provided under this subsection) with respect to expenditures incurred by it for services provided by any person during any period that an order for denial of payment (as authorized by section 1107(c)(8)(B)) is effective with respect to such person.

(2) Any order for denial of payment issued with respect to any person under section 1107(c)(8)(B) of this Act shall become effective, in the case of any State plan approved under this title, on the sixth day after the date on which the Secretary gives notice of such order to the State agency administering or supervising the administration of the plan. Any such order shall cease to be effective not later than two years from the date upon which the determination to assess a penalty under section 1107 of this Act became final. Upon the determination of the Secretary that any such order shall cease to be effective, he shall forthwith notify each State agency to which he has theretofore submitted notice under section 1107(c)(8)(B) with respect to such person.

(3) Whenever any order which has been issued by the Secretary under section 1107(c)(8)(B) ceases to be effective, any payment to which any State would (except for the preceding provisions of this subsection) have been entitled under this section on account of services provided by such person shall be made to such State for the month in which such order ceases to be effective.

(4) Any order for denial of payment to a skilled nursing facility under section 1866(f) of the Act shall become effective on the date so specified by the Secretary.

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WITHHOLDING OF FEDERAL SHARE OF PAYMENTS FOR CERTAIN MEDICARE PROVIDERS

SEC. 1913. (a) The Secretary may adjust, in accordance with this section, the Federal matching payment to a State with respect to expenditures for medical assistance furnished in any quarter by—

(1) an institution (A) which has or previously had in effect an agreement with the Secretary under section 1866; and (B)(i) from which the Secretary has been unable to recover overpayments made under title XVIII, or (ii) from which the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under title XVIII; and

(2) any person (A) who (i) has previously accepted payment on the basis of assignment under section 1842(b)(3)(B)(ii), and

(ii) during the annual period immediately preceding such quarter submitted no claims for payment under title XVIII, or submitted claims for payment under title XVIII which aggregated less than the amount of overpayments made to him, and (B) (i) from whom the Secretary has been unable to recover overpayments received in violation of section 1842(b)(3)(B)(ii), or (ii) from whom the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such person under title XVIII.

(b) The Secretary may (subject to the remaining provisions of this section) reduce payment to a State under this title for any quarter by an amount equal to the lesser of the Federal matching share of payments to any provider specified in subsection (a), or the total overpayments to such provider under title XVIII, and may require the State to reduce its payment to such provider by such amount.

(c) The Secretary shall not make any adjustment in the payment to a State, nor require any adjustment in the payment to a provider of services, pursuant to subsection (b) until after he has provided adequate notice (which shall be not less than 60 days) to the State agency and the provider of services.

(d) The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall (1) determine the amount of the Federal payment to which the provider would otherwise be entitled under this section which shall be treated as a setoff against over payments under title XVIII, and (2) assure the restoration to the provider of amounts withheld under this section which are ultimately determined to be in excess of overpayments under this section which are ultimately determined to be in excess of overpayments under title XVIII and to which the provider would otherwise be entitled under this title.

(e) The Secretry shall restore to the trust funds established under sections 1817 and 1841, as appropriate, amounts recovered under this section as setoffs against overpayments under title XVIII.

(f) Notwithstanding any other provision of this title, a provider shall not be entitled to recover from any State any amount in payment for medical care and services under this title which is withheld by the State agency pursuant to an order by the Secretary under subsection (b).

HOSPITAL PROVIDERS OF SKILLED NURSING AND INTERMEDIATE CARE SERVICES

SEC. 1914. (a) Notwithstanding any other provision of this title, payment may be made, in accordance with this section, under a State plan approved under this title for skilled nursing facility services and intermediate care facility services furnished by a hospital which has in effect an agreement under section 1882.

(b)(1) Payment to any such hospital, for any skilled nursing or intermediate care facility services furnished, shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under this title to skilled nursing and intermediate care facilities located in the State in which the hospital is

located. The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(2) With respect to any period for which a hospital has an agreement under section 1882, in order to allocate routine costs between hospital and long-term care services, the total reimbursement for routine services received from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital total routine costs before calculations are made to determine title XIX reimbursement for routine hospital services.

(c) The State plan may provide an alternative method for determining the amount of payment for long-term care services furnished in a distinct part of a hospital (where the conditions described in section 1882(g) are met) that is the same as the method prescribed in subsection (b) of this section for determining the amount of payment for such services furnished by a hospital that uses beds interchangeably for either acute or long-term care.

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